EMPLOYEE HEALTH BENEFITS IMPROVEMENT ACT OF 1988

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

H.R. 4951

TO AMEND THE INTERNAL REVENUE CODE OF 1986 TO REQUIRE EMPLOYERS TO PROVIDE HEALTH BENEFITS PLANS TO EMPLOYEES

AUGUST 9 AND SEPTEMBER 22, 1988

Serial 100-81

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EMPLOYEE HEALTH BENEFITS IMPROVEMENT ACT OF 1988

TUESDAY, AUGUST 9, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room B-318, Cannon House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearings and a copy of the bill, H.R. 4951, follow:]

FOR IMMEDIATE RELEASE
MONDAY, JULY 18, 1988

PRESS RELEASE #22
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON H.R. 4951, THE EMPLOYEE HEALTH BENEFIT IMPROVEMENT ACT OF 1988, TO BE HELD ON TUESDAY, AUGUST 9, 1988

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on H.R. 4951, the Employee Health Benefit Improvement Act of 1988. The hearing will be held on Tuesday, August 9, 1988, beginning at 10:00 a.m. in room B-318 Rayburn House Office Building.

In announcing the hearing Chairman Stark said, "In 1986 there were approximately 37 million Americans without health insurance and another seven to ten million Americans with partial coverage. There is no such thing as a non-catastrophic encounter with the health care system when a family is poor and has no health insurance.

"The bill I have introduced is not a panacea for this problem, but it is a start. I hope that it will enhance a debate that focuses not simply on mandatory employment-related benefits, but more importantly on the broader issue of what is the best, most efficient way to assure every citizen's right to basic health protection."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

H.R. 4951 would require every employer to provide a minimum level of health benefits to every employee working more than 17.5 hours per week. The benefits would have to be equal in scope to those provided by Medicare except that the plan could impose a deductible of up to $1,000 per individual and $1,500 per family. Employers who did not comply would be subject to a tax penalty.

The bill would establish risk pools in each State. Each state would have the option of creating its own pool, but the Secretary of Health and Human Services would be empowered to establish a pool in any state which did not voluntarily do so. Premiums for insurance from the pool would be capped at 150 percent of the statewide average premium for similar insurance.

Low-income employees would receive assistance in paying their share of insurance premiums (capped at 20 percent) through an income tax credit similar to the existing earned income tax credit. The self-employed would be encouraged to purchase health insurance through an increase from 25 percent to 100 percent in the deduction for health insurance premiums.

(MORE)

In 1986 there were an estimated 36.9 million Americans without health insurance and another seven to ten million Americans with partial coverage for a portion of the year. The number of uninsured Americans is growing. Fifteen percent of the non-farm population were not covered in 1980, while about eighteen percent were not covered in 1986.

The majority of the uninsured are employed. Nineteen million people or fifty-five percent of the uninsured were employees and almost seventy percent of this population live in families of full-time, full-year workers. For most of these families, the family head experienced no unemployment.

A recent survey by the Robert Wood Johnson Foundation confirmed a decline in access to care since the Foundation's 1982 study. This decline in access was particularly harsh for the poor, minorities, and for the uninsured. For example, 13.5 million Americans reported not receiving medical care for financial reasons. The study found an eight percent decline in physician visits by the poor in fair or poor health between 1982 and 1986.

Lack of health insurance coverage often means that proper care is delayed until the problem is serious. Research shows that uninsured persons are less likely to see a physician in a year, less likely to have children appropriately immunized, less likely to receive prenatal care, and less likely to see a physician if they have serious symptoms. Medical care for the uninsured often begins at the hospital, instead of beginning with primary medical care provided in a physician's office.

The increase in bad debt and charity care is putting a difficult burden on those hospitals which provide care to the uninsured. In 1985, hospitals provided approximately $7.4 billion in uncompensated care. Public hospitals with about 21 percent of hospital beds provide 55 percent of all charity care.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, August 30, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 8, 1988

PRESS RELEASE #24
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON H.R. 4951, THE EMPLOYEE HEALTH BENEFIT IMPROVEMENT ACT OF 1988, TO BE HELD ON THURSDAY, SEPTEMBER 22, 1988

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on H.R. 4951, the Employee Health Benefit Improvement Act of 1988. The hearing will be held on Thursday, September 22, 1988, beginning at 10:00 a.m. in the Main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing Chairman Stark said, "The goal of comprehensive health benefits for all is one that has eluded us since the Congress first took up the question of universal health insurance in 1918. It seems amazing to me that we continue to let hard-working Americans fall between the cracks."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

H.R. 4951 would require every employer to provide a minimum level of health benefits to every employee working more than 17.5 hours per week. The benefits would have to be equal in scope to those provided by Medicare except that the plan could impose a deductible of up to $1,000 per individual and $1,500 per family. Employers who did not comply would be subject to a tax penalty.

The bill would establish risk pools in each State. Premiums for insurance from the pool would be capped at 150 percent of the statewide average premium for similar insurance.

Low-income employees would receive assistance through an income tax credit. The self-employed health insurance deduction would be increased to 100 percent.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, October 7, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

(MORE)

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

I

100TH CONGRESS
2D SESSION

H. R. 4951

To amend the Internal Revenue Code of 1986 to require employers to provide health benefits plans to employees.

IN THE HOUSE OF REPRESENTATIVES

JUNE 29, 1988

Mr. STARK introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend the Internal Revenue Code of 1986 to require employers to provide health benefits plans to employees.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Employee Health Benefits Improvement Act of 1988".

SEC. 2. MANDATED EMPLOYER COVERAGE OF HEALTH CARE FOR EMPLOYEES.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to group health plans) is amended by adding at the end thereof the following new sections:

"SEC. 5000A. FAILURE TO PROVIDE COVERAGE TO EMPLOYEES UNDER A GROUP HEALTH PLAN.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of an employer to offer to its employees coverage under a group health plan in accordance with subsection (e).

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to an employee shall be $100 for each day in the noncompliance period with respect to such failure.

"(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

"(A) beginning on the date such failure 1st occurs, and

"(B) ending on the date such failure is corrected.

"(2) $100 LIMIT FOR FAILURES ON ANY DAY WITH RESPECT TO AN EMPLOYEE.—The maximum amount of tax imposed by subsection (a) on failures on any day during the noncompliance period with respect to an employee shall be $100.

"(c) LIABILITY FOR TAX.—The employer shall be liable for the tax imposed by subsection (a).

"(d) EXCEPTIONS.—

"(1) CERTAIN PLANS.—No tax shall be imposed by subsection (a) on—

"(A) any governmental plan (within the meaning of section 414(d)), or

"(B) any church plan (within the meaning of section 414(e)).

"(2) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (c) knew, or exercising reasonable diligence would have known, that such failure existed.

"(3) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected during the 1st 30 days of the noncompliance period with respect to such failure.

"(4) TAX NOT TO APPLY IF COVERAGE OFFERED RETROACTIVELY.—No tax shall be imposed by subsection (a) on any failure for any day if coverage is offered (whether or not retroactively) for such day.

"(5) Waiver by secretary.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be unduly burdensome relative to the failure involved.

"(e) Health Care Coverage Requirements of Group Health Plans.—

"(1) Required coverage under plan.—

"(A) In general.—

"(i) Requirement.—A group health plan meets the requirements of this subsection only if, except as provided in clause (iii), coverage is provided under the plan in accordance with this subsection on the basis of enrollment of the employee only (in this subsection referred to as 'individual enrollment') and on the basis of enrollment of the employee and the employee's family members (in this subsection referred to as 'family enrollment').

"(ii) Nonwaivability.—Except as provided under clause (iii), coverage under a plan may be not waived by an employee or an employee's family members.

"(iii) EXCEPTIONS FOR DUPLICATE FAMILY COVERAGE—

"(I) SPOUSE OR PARENT EMPLOYED.—An employee, at the employee's option, may waive coverage in a group health plan for a family member of the employee, but only for such period as the employee demonstrates that such family member is actually covered under a health benefit plan because the family member (or, in the case of a child, the child's other parent) is also an employee.

"(II) CHILD EMPLOYED.—In the case of a family member who is a child and who is employed, the family member may waive coverage in a group health plan provided by the child's employer during any period in which the child is covered under a group health plan under this section due to the employment of the child's parent.

"(iv) **NONDISCRIMINATION.**—An employer may not fail or refuse to hire, or may not discharge or otherwise discriminate against, any individual because the individual has a family member and such employer is required under this section to provide coverage of the family member in a group health plan.

"(B) **DETERMINATION OF COMPLIANCE.**—

"(i) **IN GENERAL.**—The Secretary of Health and Human Services shall determine whether a group health plan meets the requirements of this subsection.

"(ii) **COMPLIANCE WITH STATE REQUIREMENTS.**—If the Secretary of Health and Human Services determines that a State has in effect a law that establishes requirements for insured group health plans equivalent to the requirements under this subsection, the Secretary may provide that group health plans that the State certifies under such a law as meeting such requirements are deemed to meet the requirements of this subsection.

"(2) **BENEFITS.**—

"(A) IN GENERAL.—Except as provided in this paragraph, the plan must provide for coverage of health care benefits not less in amount, duration, or scope than those provided under title XVIII of the Social Security Act and must provide coverage for maternal and infant care (as defined in subsection (g)(4)). Such coverage shall become effective for services furnished not later than the first day of the first month beginning 30 days after the date of employment of the employee.

"(B) CATASTROPHIC LIMIT.—

"(i) IN GENERAL.—The plan may not provide for any deductibles, coinsurance, copayments, or similar charges—

"(I) for maternal and infant care, or

"(II) for other items and services required to be furnished under the plan with respect to an employee and the family members of the employee after they have incurred in a calendar year expenses for such items and services in the amount of $1,000 for individual enrollment and $1,500 for family enrollment.

"(ii) Indexing of dollar limit.—For any year after 1989, the dollar amount specified under clause (i) shall be increased to reflect the relative increase in the consumer price index for all urban consumers between 1988 and the year before such year.

"(C) Exclusions.—

"(i) In general.—Except as provided in this subparagraph, the plan may exclude coverage of items and services in the manner specified in section 1862(a) of the Social Security Act.

"(ii) Certain preventive coverage.—The plan may not exclude coverage for maternal and infant care.

"(D) Outpatient prescription drugs not required.—The plan is not required to provided coverage of outpatient prescription drugs and biologicals.

"(E) No pre-existing condition limitation.—The plan may not deny coverage of any item or service because the item or service relates to any condition which existed previous to coverage under the plan.

"(F) LIMITATION ON PROVIDERS.—The plan may limit the persons from or through whom benefits are available so long as beneficiaries are provided reasonable access to health care.

"(G) RATES OF PAYMENT.—The plan shall provide for rates of payment—

"(i) for items and services described in such that the rates in the aggregate insure access to covered items and services and assure a level of quality of items and services equal to at least the level enjoyed by individuals entitled to benefits under title XVIII of the Social Security Act, and

"(ii) for maternal and infant care which are not less than payment rates specified by the Secretary.

"(3) PREMIUM.—

"(A) IN GENERAL.—The plan may not require payment of a premium or similar charge which exceeds, for individual or family enrollment, the actual cost of the plan with respect to coverage within such enrollments, less the minimum contribution amount described in subparagraph (B).

"(B) MINIMUM CONTRIBUTION AMOUNT.—The minimum contribution amount described in this subparagraph is 80 percent of the actuarial value for the least expensive group health plan which is offered by the employer to employees in the State and which meets the requirements of paragraph (2).

"(C) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(i) IN GENERAL.—Except as provided in clause (ii), the premium for any period shall be determined based on a reasonable estimate of the cost of providing coverage for such period which—

"(I) is determined on an actuarial basis, and

"(II) takes into account such factors as the Secretary may prescribe in regulations.

"(ii) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this clause apply, the premium for any period shall be equal to—

"(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (D), adjusted by

"(II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(iii) CLAUSE (ii) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

"(D) DETERMINATION PERIOD.—The determination of any premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"(E) PAYMENT OF PREMIUMS.—An employee provided coverage under a group health plan under this section is liable for payment of premiums required under the plan in accordance with this paragraph.

"(4) ELECTION.—

"(A) IN GENERAL.—Except as provided in subparagraphs (A) and (B), the plan must permit each individual who is an employee, during a 30-day period beginning on the date the individual first becomes an employee for an employer, the opportunity of enrolling under a plan under this subsection.

"(B) CURRENT EMPLOYEES.—In the case of an individual employed as of the effective date of this section, the plan must permit each such individual, during the 30-day period beginning on such effective date, the opportunity of enrolled under a plan under this subsection.

"(C) EXCEPTION WHERE NO RISK POOL ESTABLISHED.—In the case of an employer in a State where no qualified health care pool has been established under section 5000B and who can demonstrate that it cannot obtain health care coverage under the terms from which it would be available through such a health care pool, the elections provided under subparagraphs (A) and (B) shall not apply until the first date such coverage is made available from such a qualified health care pool.

"(5) NOTICE REQUIREMENT.—In accordance with regulations prescribed by the Secretary, each group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each employee of the rights provided under this subsection.

"(6) CONTINUATION FOR 2 MONTHS AFTER LAYOFF.—The plan must provide for continuation of coverage through the end of the second month that begins after the date an individual covered under the plan is involuntarily terminated, under the same terms and conditions as would apply if the individual's employment had been continued.

"(7) PREEMPTION.—This section shall supercede State laws insofar as they may now or hereafter prevent an employer from offering coverage under a group health plan that meets the requirements of this section.

"(f) DEFINITIONS.—For purposes of this section—

"(1) EMPLOYEE.—

"(A) IN GENERAL.—The term 'employee' means any individual who works at least 17½ hours per week for an employer.

"(B) EXCEPTION FOR NONRESIDENT ALIENS.—The term 'employee' does not include an individual whose status as an employee is attributable to a period in which such individual was a nonresident alien who received no earned income (within the meaning of section 911(d)(2)) from the employer which constituted income from sources within the United States (within the meaning of section 861(a)(3)).

"(2) FAMILY MEMBER.—The term 'family member' means, with respect to an employee—

"(A) the employee's spouse,

"(B) any child of the employee under 18 years of age, "(C) a child of the employee under 26 years of age if the employee (or the employee's spouse) claims the child as a dependent for purposes of section 151, and

"(D) any child of the employee if the child became disabled (as defined by the Secretary) before the age of 18 and if the employee (or the employee's spouse) claims the child as a dependent for purposes of section 151.

"(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 162(i).

"(4) MATERNAL AND INFANT CARE DEFINED.—The term 'maternal and infant care' means items and services related (as determined by the Secretary of Health and Human Services in consultation with the American College of Obstetricians and Gynecologists) to pregnancy, to delivery, to care of a child through one year after birth, or to care of a woman through 60 days after termination of pregnancy.

"(5) PLAN ADMINISTRATOR.—The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

"(6) Correction.—A failure of a group health plan to meet the requirements of subsection (e) with respect to any employee shall be treated as corrected if—

"(A) such failure is retroactively undone to the extent possible, and

"(B) the employee (and family members)—

"(i) is placed in a financial position which is as good as such employee members would have been in had such failure not occurred, and

"(ii) is treated as if he had elected the most favorable coverage in light of the expenses the employee incurred since the failure first occurred."

"(7) Employee, wages, employment.—

"(A) In general.—Except as provided in subparagraph (B), the terms 'employee', 'wages', and 'employment' have the meanings given such terms in section 3121 (definitions of terms for purposes of the Federal Insurance Contributions Act).

"(B) Special rules.—

"(i) Wages.—In applying section 3121(a) (relating to definition of wages), paragraph (1) shall not apply.

"(ii) Employment.—In applying section 3121(b) (relating to definition of employment)—

"(I) such term shall not include service performed in the employ of the United States or any instrumentality thereof, and

"(II) paragraph (7) thereof paragraph (7) (relating to employment by a State or political subdivision) shall not apply.

"SEC. 5000B. TAX ON EMPLOYERS IN STATES WHICH FAIL TO PROVIDE FOR QUALIFIED HEALTH CARE POOLS.

"(a) General Rule.—There is hereby imposed on every employer for each calendar year an excise tax, with respect to having individuals in his employ in a State, equal to the percentage (specified in subsection (c)(2)) of the total wages (as defined in section 5000A(f)(7)) paid by him during the calendar year with respect to employment (as defined in section 5000A(f)(7)) in the State.

"(b) **Exception for Employment in States With Qualified Health Care Pools.**—

"(1) **In general.**—The excise tax imposed under subsection (a) shall not apply to employment in a State during any calendar year in which the Secretary of Health and Human Services determines the State has in operation a qualified health care pool (as defined in paragraph (2)).

"(2) **Qualified health care pool defined.**—In this subsection, the term 'qualified health care pool' means, with respect to a State, a plan under which—

"(A) health care coverage meeting the requirements of section 5000A(e) (other than those of paragraph (3), relating to premiums) is made available to all employers in the State, and to all individuals (and family members) residing in the State,

"(B) the premium required for such coverage does not exceed 150 percent of the average cost of a group standard risk policy in the State; and

"(C) any losses from the operation of the plan are paid for through payments by employers in the State, in proportion to each employer's wages paid for employment in the State.

"(c) Establishment of Federal Pool.—In the case of any State which does not have a qualified health care risk pool for any calendar year, the Secretary of Health and Human Services—

"(1) through a competitive bidding process, shall designate an entity to operate a health care pool that meets the requirements of subparagraphs (A) and (B) of subsection (b)(2), and

"(2) shall establish a percentage, to be applied to employment in the State under subsection (a), which the Secretary estimates, in consultation with the Secretary of the Treasury, will provide revenues reasonably required to meet any losses from the operation of the pool."

(b) Deficiency Procedures to Apply to Chapter 47.—

(1) The following provisions of the Internal Revenue Code of 1986 are each amended by striking "or 45" each place it appears and inserting "45, or 47".

(A) Subsections (a) and (b)(2) of section 6211.

(B) Section 6212(a).

(C) Subsections (a) and (g) of section 6213.

(D) Subsections (c) and (d) of section 6214.

(E) Section 6161(b)(1).

(F) Section 6344(a)(1).

(G) Section 7422(e).

(2) Sections 6211(a) and 6862(a) of such Code are each amended by striking "and 45" and inserting "45, and 47".

(3) Paragraph (1) of section 6212(b) of such Code is amended—

(A) by striking "or chapter 45" and inserting ", chapter 45, or chapter 47", and

(B) by striking "chapter 45, and this chapter" and inserting "chapter 45, chapter 47, and this chapter".

(4) Paragraph (1) of section 6212(c) of such Code is amended by striking "or of chapter 45 tax for the same taxable period" and inserting ", of chapter 45 tax for the same taxable period, or of chapter 47 for each act or failure to act to which the petition relates".

(5) Subsections (a) and (b)(1) of section 6512 of such Code are each amended inserting "or 47" after "or 44" each place it appears.

(c) Technical Amendments.—Sections 414(n)(3)(C) and 414(t)(2) of such Code are each amended by inserting "5000A, 5000B" after "162(k),".

(d) Clerical Amendments.—

(1) So much of chapter 47 of such Code as precedes subsection (a) of section 5000 is amended to read as follows:

"CHAPTER 47—TAXES RELATING TO GROUP HEALTH PLANS".

"Sec. 5000. Contributions to nonconforming large group health plans.
"Sec. 5000A. Failure to provide coverage to employees under a group health plan.
"Sec. 5000B. Tax on employers in States which fail to provide for qualified health care pools.

"SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE GROUP HEALTH PLANS."

(2) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 47 and inserting the following:

"Chapter 47. Taxes relating to group health plans."

(d) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

SEC. 3. ASSISTANCE TO LOW-INCOME EMPLOYEES.

(a) Group Health Plan Premium Tax Credit.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

"SEC. 35. GROUP HEALTH PLAN PREMIUMS.

"(a) ALLOWANCE OF CREDIT.—In the case of an eligible individual, there is allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the amount of the premiums paid by the individual for a group health plan offered to the individual under section 5000A.

"(b) LIMITATION.—The amount of the credit allowable to a taxpayer under subsection (a) for any taxable year shall not exceed the least of—

"(1) 10 percent of so much of the earned income for the taxable year as does not exceed $8,000;

"(2) the excess (if any) of—

"(A) the maximum credit allowable under paragraph (1) to any taxpayer, over

"(B) 10 percent of so much of the adjusted gross income (or, if greater, the earned income) of the taxpayer for the taxable year as exceeds $8,000; or

"(3) the amount of the premiums the individual could have paid for the least expensive group health plan offered to the individual under section 5000A.

"(c) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who, for the taxable year, is an employee (within the meaning of section

5000A(f)(1)), but does not include an individual who, for the taxable year, claims the benefits of section 911 (relating to citizens or residents of the United States living abroad).

"(2) EARNED INCOME.—

"(A) The term 'earned income' means—

"(i) wages, salaries, tips, and other employee compensation, plus

"(ii) the amount of the taxpayer's net earnings from self-employment for the taxable year (within the meaning of section 1402(a)),

but only during a period in the taxable year in which the taxpayer is an employee (within the meaning of section 5000A(f)(1)).

"(B) For purposes of subparagraph (A)—

"(i) the earned income of an individual shall be computed without regard to any community property laws,

"(ii) no amount received as a pension or annuity shall be taken into account, and

"(iii) no amount to which section 871(a) applies (relating to income of nonresident alien individuals not connected with United States business) shall be taken into account.

"(d) MARRIED INDIVIDUALS.—In the case of an individual who is married (within the meaning of section 7703), this section shall apply only if a joint return is filed for the taxable year under section 6013.

"(e) TAXABLE YEAR MUST BE FULL TAXABLE YEAR.—Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allowable under this section in the case of a taxable year covering a period of less than 12 months.

"(f) AMOUNT OF CREDIT TO BE DETERMINED UNDER TABLES.—

"(1) IN GENERAL.—The amount of the credit allowed by this section shall be determined under tables prescribed by the Secretary.

"(2) REQUIREMENTS FOR TABLES.—The tables prescribed under paragraph (1) shall reflect the provisions of subsections (a) and (b) and shall have income brackets of not greater than $50 each—

"(A) for earned income between $0 and the amount of earned income at which the credit is phased out under subsection (b), and

"(B) for adjusted gross income between the dollar amount at which the phase-out begins under subsection (b) and the amount of adjusted gross income at which the credit is phased out under subsection (b).

"(g) COORDINATION WITH ADVANCE PAYMENTS OF GROUP HEALTH PLAN PREMIUM CREDIT.—

"(1) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If any payment is made to the individual by an employer under section 3507A during any calendar year, then the tax imposed by this chapter for the individual's last taxable year beginning in such calendar year shall be increased by the aggregate amount of such payments.

"(2) RECONCILIATION OF PAYMENTS ADVANCED AND CREDIT ALLOWED.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit (other than the credit allowed by subsection (a)) allowable under this subpart.

"(h) REDUCTION OF CREDIT TO TAXPAYERS SUBJECT TO ALTERNATIVE MINIMUM TAX.—The credit allowed under this section for the taxable year shall be reduced by the amount of tax imposed by section 55 (relating to alternative minimum tax) with respect to such taxpayer for such taxable year.

"(i) INFLATION ADJUSTMENTS.—

"(1) In general.—In the case of any taxable year beginning after 1990, the $8,000 amount contained in subsection (b) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3), for the calendar year in which the taxable year begins, by substituting 'calendar year 1989' for 'calendar year 1987' in subparagraph (B) thereof.

"(2) Rounding.—If any increase determined under paragraph (1) is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10 (or, if such increase is a multiple of $5, such increase shall be increased to the next higher multiple of $10)."

(b) Advance Payment of Credit.—

(1) In general.—Chapter 25 of such Code is amended by inserting after section 3507 the following new section:

"SEC. 3507A. ADVANCE PAYMENT OF HEALTH PLAN PREMIUM CREDIT.

"(a) General Rule.—Except as otherwise provided in this section, every employer making payment of wages to an employee with respect to whom a health plan premium eligibility certificate is in effect shall, at the time of paying such wages, make an additional payment to such employee equal to such employee's health plan premium advance amount.

"(b) HEALTH PLAN PREMIUM ELIGIBILITY CERTIFICATE.—For purposes of this title, a health plan premium eligibility certificate is a statement furnished by an employee to the employer which—

"(1) certifies that the employee will be eligible to receive the credit provided by section 35 for the taxable year,

"(2) certifies that the employee does not have a health plan premium eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer, and

"(3) states whether or not the employee's spouse has a health plan premium eligibility certificate in effect.

For purposes of this section, a certificate shall be treated as being in effect with respect to a spouse if such a certificate will be in effect on the first status determination date following the date on which the employee furnished the statement in question.

"(c) HEALTH PLAN PREMIUM ADVANCE AMOUNT.—

"(1) IN GENERAL.—For purposes of this title, the term 'health plan premium advance amount' means, with respect to any payroll period, the amount determined—

"(A) on the basis of the employee's wages from the employer for such period, and

"(B) in accordance with tables prescribed by the Secretary.

"(2) ADVANCE AMOUNT TABLES.—The tables referred to in paragraph (1)(B)—

"(A) shall be similar in form to the tables prescribed under section 3402 and, to the maximum extent feasible, shall be coordinated with such tables, and

"(B) if the employee is not married, or if no health plan premium eligibility certificate in effect with respect to the spouse of the employee, shall treat the credit provided by section 35 as if it were a credit—

"(i) of not more than 10 percent of earned income not in excess of the amount of earned income which may be taken into account under section 35(b)(1), which

"(ii) phases out between the amount of earned income at which the phaseout begins under paragraph (2) of section 35(b) and the amount of earned income at which the credit under section 35 is phased out under such paragraph, or

"(C) if a health plan premium eligibility certificate in effect with respect to the spouse of the employee, shall treat the credit provided by section 35 as if it were a credit—

"(i) of not more than 10 percent of earned income not in excess of ½ of the amount of earned income which may be taken into account under section 35(b)(1), which

"(ii) phases out between amounts of earned income which are ½ of the amounts of earned income described in subparagraph (B)(ii).

"(3) LIMITATION.—In no event shall the aggregate of the health plan premium advance amounts for any calendar year exceed the lesser of the amount described in section 35(a) or the amount described in section 35(b)(3) for such year.

"(d) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (d) and (e) of section 3507 shall apply for purposes of this section. Proper adjustments shall be made in the application of such rules under this section to take into account payments under section 3507."

(2) INFORMATION SHOWN ON W-2.—Subsection (a) of section 6051 of such Code (relating to receipts to employees) is amended by striking the period at the end of paragraph (8) and inserting ", and" and by inserting after paragraph (8) the following new paragraph:

"(9) the total amount paid to the employee under section 3507A (relating to advance payment of group health plan premium credit)."

(3) REQUIREMENT OF RETURN.—Subsection (a) of section 6012 of such Code (relating to persons required to make returns of income) is amended by inserting after paragraph (9) the following new paragraph:

"(10) Every individual who receives payments during the calendar year in which the taxable year begins under section 3507A (relating to advance payment of group health plan premium credit)."

(4) CROSS REFERENCE.—Subsection (e) of section 6302 of such Code (relating to mode or time of collection) is amended by adding at the end thereof the following new paragraph:

"(3) For treatment of health plan premium advance amount as payment of withholding and FICA taxes, see section 3507A(d)."

(c) Clerical Amendments.—

(1) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 35 and inserting the following:

"Sec. 35. Group health plan premiums.
"Sec. 36. Overpayments of tax."

(2) The table of sections for chapter 25 of such Code is amended by inserting after the item relating to section 3507 the following new item:

"Sec. 3507A. Advance payment of group health plan premium credit."

(d) Effective Dates.—

(1) The amendments made by subsections (a) and (b)(3) shall apply to taxable years beginning after December 31, 1988.

(2) The amendments made by paragraphs (1) and (2) of subsection (b) shall apply to remuneration paid after December 31, 1988.

SEC. 4. DEDUCTION FOR ALL HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) In General.—Paragraph (1) of section 162(m) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking "25 percent of"

(b) DEDUCTION MADE PERMANENT.—Subsection (m) of section 162 of such Code is amended by striking out paragraph (4).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

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Chairman **Stark**. The subcommittee will come to order.

Today the Health Subcommittee of the Committee on Ways and Means will begin a series of hearings on mandated health insurance for all employees and on H.R. 4951, the Employee Health Benefits Improvement Act of 1988. This bill would require employers to provide health insurance to all full-time workers and their dependents.

In 1986 there were an estimated 37 million Americans without health insurance. Amazingly, 70 percent of these individuals lived in families with full-time, full-year workers.

I believe that basic health insurance is a right of every American. Unfortunately our society clearly has not yet reached that goal, and we appear to be slipping further away every year.

H.R. 4951 is intended to be an incremental step toward reaching our goal of universal coverage. It is not a panacea. There are a number of issues which must be resolved prior to reporting a final bill requiring comprehensive health benefits for workers.

The content of a minimum benefit package is a particularly contentious issue. H.R. 4951 uses Medicare as a model for the benefit package and adds coverage for maternal and infant care. There are, of course, other approaches, and I look forward to further discussion on this point.

Another important benefit issue is that over the last several years the States have mandated a host of benefits and services which must be included in group health insurance policies in those States. Although these mandates may make sense in isolation, they do present problems for companies and unions operating on a national scale.

H.R. 4951 would preempt these State mandates so that we could move from a patchwork quilt of mandates to a national program which truly responds to the needs of every citizen.

Nevertheless I continue to be concerned about the impact of a Federal mandate and whether it will reduce the level of services to some. As a result, I look forward to a vigorous discussion of the pros and cons of State mandates.

The goal of comprehensive health benefits for all is one that has eluded us since the Congress first took up the question of universal health insurance in 1918. It seems amazing to me that we continue to let hard-working Americans fall between the cracks.

I had the privilege of reminding, in jest, Senator Pepper and Congressman Dingell—whose father raised the issue of mandated health benefits many years ago that my great-great-grandfather voted with Kaiser Wilhelm in the German Republic and they have led the way. I hope after all these years the Stark family can see health coverage for every citizen in the Nation.

I hear every day from constituents who do not have health insurance or cannot obtain it. Miss Wendy Walker of Hayward, California, wrote to me to report that she cannot obtain any coverage for the high costs of cardiac care because she has had a heart condition since birth. Another constituent, Frank Budds of Castro Valley, California, wrote to tell me about the catastrophic impact of an $8,100 bill for the birth of his daughter when his family was without health insurance. I believe a caesarean was involved there and she would not be eligible now.

I will make their letters part of the record of this hearing.

[The following was subsequently received:]

JULY 25, 1988.

PETE F. STARK,
Representative, Ninth District,
Congress of the United States, Hayward, CA.

DEAR MR. STARK: I am writing to you for your help. I am 23 years old, single, and no longer covered by my parents' medical insurance. I have had a heart condition since birth and go for yearly check-ups to a cardiologist. I have been doing fine.

My problem is that I cannot find an insurance company that will cover me in case something happens concerning my heart condition. Neither I nor my parents could afford the hospital/medical costs. I am willing to pay for my yearly check-ups, if need be, and also the non-heart related doctor/medical visits. I am only seeking medical insurance in case something happens to my heart or anything in connection with it.

I am presently working for a firm. Their insurance does not cover pre-existing conditions.

I cannot see how the Representatives of this country can allow insurance companies to exclude anyone from their coverage because of a "pre-existing condition." It is not fair!

I hope you can help me, or give me suggestions on what I can do. This situation is very scary. I would appreciate a response from you as soon as possible. Thank you.

Sincerely yours,

WENDY WALKER, *Hayward, CA.*

CASTRO VALLEY, CA, *June 12, 1988.*

Congressman PETE STARK,
Hayward, CA.

DEAR PETE: I am asking for any assistance you can give regarding the exorbitant medical costs my wife and I are experiencing to have children. It took approx. $8,100.00 to have pre-natal care, and give birth to my 18-month-old, Diana. We are expecting another child to be born in November at higher rates.

We have no medical insurance. Several large companies including Prudential and Blue Cross refused to insure us when they were informed that Diana was born via an emergency Caesarean Section. I am unemployed, and am experiencing a frustrating job search. I was laid off from my last job, two days before medical insurance was to begin.

Please respond.

Sincerely yours,

FRANK C. BUDDS.

Chairman STARK. The rising level of interest in responding to this problem means that we may finally make meaningful progress toward solving it. I hope that H.R. 4951 will make a contribution toward that end.

There are probably only a million or so Americans who are turned away and maybe many more who think they cannot get insurance at all and are scared away. If this is the case, it means that out of this 37 million who have no insurance, someone is getting care somewhere. How is this happening?

What I would suggest is that we are paying for it right now. We who are fortunate enough to have health insurance are paying for it with higher premiums. We are paying for it with higher daily hospital costs because the hospitals charge a little extra for uncompensated care. We are even paying for it with higher doctor bills for all the care those doctors give on Wednesday afternoons to care for the poor and indigent. It is costing all of us more to pay for this.

It seems to me what we are really talking about is perhaps a fairer way of spreading the cost for care that is already being provided, albeit sometimes too little and too late.

I hope we can work together with all the parties who have an interest in this in the years ahead. Whichever administration we will be dealing with next year, I hope we can move ahead to see if this is a benefit or service to the American people that we can provide in a way that will be acceptable to a broad majority.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

I want to congratulate you for arranging this hearing on such an important subject.

The issue of mandated benefits does not involve a particularly new idea. You mentioned Bismarck, but I guess we could talk about what happened here in the 1930s. We have used, either through Federal or State mandate, benefits of this kind in a wide variety of areas: Social Security, unemployment, worker's compensation, minimum wage bills. Even the recently enacted plant closing law in a sense fits into this category of a mandated benefit.

Today there are many such proposals on the legislative agenda, of which health is only one. That is the main point I want to make. We are hearing, as we should, about the issue of health mandates, but there are many others: family relief, day care, increases in the minimum wage, et cetera.

What gives me difficulty is somebody who is not philosophically opposed to the notion of mandated benefits is to sort out the priorities involved here. Those who are for these basically come in and argue that we should do them all, do them all at the same time, and that really bothers me in terms of the potential impact on the economy.

So I hope in the course of these hearings that we can get the best possible advice from this excellent group of witnesses with regard to sorting out which are the priorities for mandated benefits in terms of the next steps we should take; and, second, if we are going to move forward in adding mandated benefits through governmental action, to what extent should it be through Federal action, as in the case of some of the things I mentioned, or through state action.

In mandated health benefits the lead was taken by Hawaii, followed more recently by Massachusetts. It doesn't in itself suggest that Federal action is or is not the appropriate course. One could argue that the States are showing the initiative in different ways and we should encourage them and give them an opportunity to move ahead, rather than impose a uniform system of benefits on the other 48.

So these are issues on my mind, Mr. Chairman. Having a chance to look over the testimony in advance, I know we are going to get valuable input today and I look forward to the testimony.

Thank you, Mr. Chairman.

Chairman **Stark**. Thank you.

Mr. Levin.

Mr. **Levin**. Just briefly, because we are all anxious to hear the witnesses, I missed the first portion of Mr. Gradison's, as always, thoughtful presentation. I would just add——

Mr. **Gradison**. The Chairman did pretty well, too.

Mr. **Levin**. Yours, as always, was thoughtful, but I didn't hear any of it. I apologize for that.

I just want to say that I think only a few of those who have been breaking the ice on the issue of mandating benefits believe there are not priorities or they all can be instituted at once. But I think new vistas have been opening up, and they are exciting new vistas.

I agree with you, we should not get into this reflexive position of all or nothing or in each case the Federal Government and the States have no role.

Anyway, I am glad to be here and again apologize for being a few minutes late. I look forward to the testimony of the distinguished witnesses.

Chairman **Stark**. We are honored to have as our first witness Owen Bieber, president of the International Union, United Auto Workers, accompanied by members of his staff, who have worked with us over the years in fashioning all kinds of health legislation.

We are honored to have the boss here today.

Mr. **Bieber**. I have with me Bill Hoffman on my right, the director of the Social Security department, and Alan Reuther on my left, the deputy general counsel.

STATEMENT OF OWEN BIEBER, PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW, ACCOMPANIED BY WILLIAM HOFFMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, AND ALAN REUTHER, DEPUTY GENERAL COUNSEL

Mr. **Bieber**. The UAW strongly endorses the proposed Employee Health Benefits Improvement Act of 1988, H.R. 4951, which would assure that all American workers and their families have access to needed health care services. We commend you, Mr. Chairman, for your effective leadership in addressing one of the most serious social problems facing this Nation: the lack of health insurance coverage for millions of working Americans and their families.

While the United States continues to be a world leader in advancing modern medicine, a substantial portion of the population lacks access to even the most basic health care services. Today an astounding 16 percent of the population—37 million Americans—lack health insurance coverage; 50 million persons are without health insurance coverage for at least part of the year.

Significantly about three-quarters of the persons without health insurance coverage are working men and women and their dependents. Although the majority of employers, including both large and small businesses, provide their workers with health insurance protection, a significant and growing minority of employers do not provide any health insurance benefits.

The UAW continues to believe that all Americans should be entitled to health insurance coverage as a basic social right. But certainly, at a minimum, there is no reason why any person who is employed, or his or her dependents, should be without this essential protection. Our society has already made a determination all employers should be required, as a condition of doing business, to provide all employees with a minimum wage, protection against unemployment—through unemployment insurance—and basic retirement income and disability insurance—through Social Security. The UAW believes it is time for this country to take the next step and require all employers to provide at least a minimum package of health insurance benefits to all their workers and their dependents.

We are greatly encouraged by the growing acceptance of this basic principle. As you know, under the leadership of Governor Dukakis, Massachusetts has recently enacted legislation which will guarantee access to basic health care for all residents of the State. This landmark legislation will require most employers in the state to provide health insurance coverage for their workers and their families. In addition, a State fund will provide health insurance coverage to individuals not covered under employer-sponsored health plans. The UAW commends Governor Dukakis for his leadership in this area and urges similar action in other States. Ultimately, however, we believe such a program needs to be implemented on a national level.

The legislation which you have introduced, Mr. Chairman, would represent a major step in this direction. In addition, we note that Senator Kennedy and Representatives Waxman, Clay, and Murphy have introduced a similar bill, the Minimum Health Benefits for All Workers Act of 1987, S. 1265, H.R. 2508. Although these two bills rely on different enforcement mechanisms and contain many other minor differences, they embrace the same fundamental principle, that all employers should be required to provide at least a minimum level of health insurance benefits to their workers and their families.

The UAW believes that these bills would accomplish two major objectives.

First, and most importantly, by guaranteeing that all American workers and their families have at least a minimum package of health insurance benefits, the bills would significantly improve access to needed medical services and thereby improve the health of millions of Americans. Because they lack health insurance coverage, too many families presently do not have access to adequate health care services. Too often they are forced to postpone or do without needed medical care because limited family income must be used for food, housing or other basic needs. Their dilemma is vividly demonstrated by the fact that the absence of health insurance has been linked with higher mortality rates in general and with higher rates of infant mortality in particular. In addition, being uninsured encourages individuals to rely on hospitals, primarily public hospital emergency rooms, for medical treatment, instead of using preventive and other types of more cost effective medical services.

Second, the bills would sharply reduce the unnecessary, inefficient and unfair cost shifting that takes place under our present health care system. This would lead to substantial savings for the Federal Government. Under present law, some of the workers and their dependents who do not receive health insurance protection from their employers wind up being covered by Medicare, Medicaid or CHAMPUS. The proposed legislation would require their employers to provide the primary health insurance coverage, and would necessarily reduce expenditures under the Federal health care programs.

Similarly, the bills would provide relief to the majority of private and public employers who current provide health insurance coverage to their own employees. Under present law, uninsured persons usually wind up being treated as uncompensated care by hospitals and other health care providers. The cost of providing this uncompensated care is not fully absorbed by hospitals and other health care providers; instead it is passed on to other private payers, mostly other employers, who already are providing health care protection.

In addition, in the situation where a worker does not receive any health insurance coverage from his or her employer, but the worker's spouse is employed by another company that does offer health insurance benefits, the worker will often enroll in the health care plan offered by the spouse's employer. In such cases the health care costs associated with the worker are directly shifted from one employer to the other.

The UAW submits that both types of cost shifting between employers are unfair. This country does not allow employers to opt out of paying social security taxes and to shift the cost of providing basic retirement benefits onto other employers. There is no reason why some employers should be allowed unfairly to shift the cost of providing basic health protection for their employees to other businesses.

The UAW is particularly concerned about the impact of this cost shifting between employers on the industrial sector of our economy. The businesses in this sector, which are already under considerable pressure as a result of ineffective and misdirected trade and economic policies, commonly provide health insurance for their workers. In contrast, employers who do not provide any health care protection tend to be in the growing service sector of our economy, which generally is not faced with pressure from international competition. Thus the fact is that manufacturing companies have been subsidizing employers in the service sector through the shifting of health care costs. Surely there cannot be any justification for continuing this massive cross-subsidy. If Congress is serious about taking steps to restore the competitiveness of our industrial base, one important measure would be to reduce the unfair shifting of health care costs by requiring every employer to pay for health insurance benefits for its own workers.

To accomplish the twin objectives of expanding access to health care and reducing unfair cost shifting, the UAW believes it is essential that three basic elements be retained in any legislation.

First, all employers must be required to provide the minimum package of health insurance benefits to their workers. There cannot be any blanket exceptions for small businesses. Nor is it sensible simply to mandate benefits for employers choosing to offer health care plans. Such proposals do not address the fundamental problem created by employers who manage to avoid offering any health coverage at all, and indeed may exacerbate that problem by encouraging some employers to cancel existing health care plans.

Second, all workers, including part-time employees working 17.5 hours or more per week, must be covered under their employers' health care plans.

Third, the health care plans provided by employers must also provide coverage for spouses and dependent children. This important profamily feature is already contained in more progressive employee benefit plans, such as major UAW negotiated health care plans.

The UAW commends you, Mr. Chairman, for incorporating these basic elements in the legislation which you have introduced.

There are also many other provisions in H.R. 4951 which we strongly support. In particular we applaud the provision requiring employers to continue health care coverage for at least 2 months after workers are laid off. This would help to bridge the gap in health care coverage for a large segment of the unemployed. Some large corporations already continue health insurance coverage for laid-off workers. For example, under major UAW contracts, health insurance coverage for laid-off workers may continue for up to 2 years, depending on length of seniority. But these contractual benefits are not typical for most workers, nor for many members of our union, who often lose health insurance coverage at the time of layoff. Requiring employers to continue health care coverage for laid-off workers will not impose an undue burden on businesses. In most cases these additional costs will represent only a small fraction of the overall health care expenditures by the employer.

Mr. Chairman, when employers fail to continue health care coverage for laid-off workers, the costs of providing coverage do not disappear. Much of these costs is simply shifted onto other payers—either the federal and State governments under Medicaid or onto the public and nonprofit community hospitals who handle most uncompensated care. Requiring employers to continue health care coverage for laid-off workers will reduce this unfair and inefficient cost shifting and will result in savings for the Federal and State Governments and for other private payers.

The UAW also supports the provision in H.R. 4951 prohibiting denial of benefits for preexisting conditions. Full coverage for these conditions has traditionally been characteristic of progressive health care plans.

In addition, the UAW supports the provision in H.R. 4951 that allows health plans to limit the number and types of providers of medical care so long as beneficiaries are provided reasonable access to care. Employers and unions should be encouraged to make innovative managed care alternatives, such as health maintenance organizations and preferred provider organizations, available to workers and their families.

Mr. Chairman, H.R. 4951 contains a provision which would preempt State laws insofar as they would prevent an employer from offering health insurance coverage meeting the requirements of the bill.

We understand that this provision is intended to allow employers to be exempt from State-mandated benefit laws in situations where the employers offer only the minimum health insurance package specified in the bill. At a minimum, the language in the bill needs to be modified to clarify this point.

Although this provision represents an important step in the right direction, in our judgment it does not go far enough. There would still be a strong disincentive for employers to offer any benefits beyond the minimum package specified in H.R. 4951, because this would subject them to all of the State-mandated benefit laws. To avoid this "cliff" effect, the UAW strongly recommends that you expand this provision to totally preempt all State laws which require employers purchasing health insurance policies to offer specific benefits or include particular types of health care providers.

Unlike the legislation which you have introduced, Mr. Chairman, State-mandated benefit laws do not help to expand access to health care. Typically these State laws simply require employers who are already offering health insurance coverage to include specific benefits or types of health care providers. Thus these State laws do nothing to address the fundamental problem of employers who choose not to offer any health insurance coverage at all.

Indeed, because these State laws add significantly to the cost of health insurance policies, they may make it more difficult for small businesses to offer health insurance coverage, and thus may actually result in less overall health insurance coverage.

The fact is that most existing State mandates do not enhance the quality of medical care. Instead they operate mainly to line the pockets of various health care providers by freezing in traditional fee-for-service practice. In some cases these laws have been used to undermine efforts by employers and unions to institute effective managed care and other cost containment programs which promote competition among medical care providers and thereby hold down increases in health care costs.

Mr. Chairman, H.R. 4951 would require all employers to provide their workers and their families with the benefits provided under Medicare, plus maternal and infant health care. The UAW believes that this minimum benefit standard is generally appropriate. However, in our judgment, the deductibles of $1,000 per individual and $1,500 per family are far too high to provide adequate protection. Many individuals and families would be bankrupt before they received any benefits. We recognize, Mr. Chairman, that you have previously indicated that the benefit standard specified in H.R. 4951 is simply a starting point for discussion. We urge you and the other members of the subcommittee to consider modifying the benefit standard to reduce these large out-of-pocket deductibles.

The UAW also suggests that a modest mental health care benefit be added to the minimum benefit standard. However, unions and employers should be given considerable latitude in designating specific arrangements for such services in terms of numbers, types and qualifications of providers, organization of and payment for services, quality assurance provisions and cost containment mechanisms.

Mr. Chairman, the UAW urges that a provision be added to H.R. 4951 which would allow employers to satisfy their obligations by providing a package of benefits which is actuarially equivalent to the value of the health benefit program specified in the legislation. This approach allows a reasonable degree of flexibility in benefit design, avoids unnecessary nitpicking of decent employee benefit plans and provides some opportunity to tailor programs to meet the needs of specific groups of workers. Furthermore, the provision would allow the vast majority of employers currently providing health insurance benefits to meet requirements of the legislation without having to amend existing benefit plans.

The UAW recognizes that the benefits specified in the legislation are only intended as a minimum standard, not a comprehensive benefit package. Through collective bargaining, unions and employers would be free to negotiate supplemental coverage to address specific unmet needs or to enhance benefits above the minimum statutory requirement. That is an appropriate role for collective bargaining, rather than relying on such bargaining to be the engine for generating a reasonable minimum level of basic health care protection for the entire nation.

The UAW has reservations about a number of the provisions in H.R. 4951. We are troubled by the provision that would allow employers to require workers to pay part of the premiums for the minimum health care coverage. We believe that employers should be required to pay for 100 percent of the premium cost. We commend you, Mr. Chairman, for at least providing added protection for low-wage workers, by allowing a refundable tax credit, similar to the earned income tax credit, for health care premiums paid by employees.

The UAW is also troubled by the provision in H.R. 4951 that would allow employed children to waive enrollment in the health plans offered by their own employers, as long as they continue to be covered under health plans provided by their parents' employers. We believe this provision will permit some employers, particularly businesses in the service sector employing a high percentage of teenagers, to continue to shift health care costs onto other employers.

Similarly the UAW is concerned about the provision that would allow a worker to waive enrollment in a health care plan for the worker's dependents if they are already covered under another employer's health care plan. To minimize unfair cost shifting, we believe some mechanism should be worked out to spread the cost of covering dependents fairly among all employers. However, we commend you, Mr. Chairman, for at least including a provision prohibiting employers for discriminating against an employee or prospective employees because they have spouses and/or dependent children. That prohibition will help prevent the profamily intent of the legislation from being undermined.

Mr. Chairman, we are disappointed that State and local governments are exempted from the requirements of H.R. 4951. The UAW has traditionally supported extension of the minimum wage to public sector employers. In our judgment, the same principle should apply to minimum health insurance coverage requirements.

Mr. Chairman, we are pleased that H.R. 4951 contains provisions designed to encourage the States to establish qualified health care pools which would make health insurance coverage available to all individuals and employers in the State. We believe such health care pools can help make health insurance coverage more affordable for small businesses. We recognize that many small businesses currently have to pay exorbitant rates and administrative charge for health insurance coverage. By creating a mechanism for pooling small groups, we believe there can be substantial savings for small businesses.

In addition, these health care pools can play a useful role in providing health insurance coverage to various categories of individuals who do not have coverage under employer-sponsored plans, and who cannot obtain coverage on their own. In particular we believe these State pools should provide coverage for the long-term unemployed, so-called uninsurable individuals and retirees of bankrupt companies who have lost their health insurance coverage.

However, we have several concerns about the way in which the qualified health care pools are structured under H.R. 4951. Most importantly, we believe that the cost of the health insurance coverage, which could be as high as 150 percent of the average cost of a group standard risk policy in the State, may prove to be exorbitant for many lower income individuals.

In order to assure access to basic health care services, it is not enough to simply make health insurance coverage available to all individuals; it is also necessary to make such coverage affordable. We therefore urge the subcommittee to explore ways in which the health insurance coverage provided by these health care pools could be subsidized for lower income individuals.

In addition, we are concerned that H.R. 4951 focuses exclusively on a payroll tax as the mechanism for distributing any losses associated with the health care pools. We believe the States should be given the flexibility to substitute more progressive revenue sources, including general revenues, if they so desire.

Finally, the UAW urges the subcommittee to consider provisions which will promote cost containment and quality assurance programs. Any legislation should require the participants in State health care pools to take certain measures toward these objectives, while permitting employers and unions providing coverage through other mechanisms to devise suitable cost containment and quality assurance mechanisms of their own.

Again, Mr. Chairman, I want to thank you for giving me the opportunity to appear on behalf of the UAW before the committee this morning.

[The portion of Mr. Bieber's statement not read follows:]

The UAW looks forward to working with you, Mr. Chairman, and the other members of the Subcommittee, on these and other matters as H.R. 4951 moves forward in the legislative process. We believe we can work together to shape a program which would represent one of the most significant pieces of social legislation in the second half of the twentieth century.

We recognize that some persons may criticize the legislation as being "anti-business". That is simply not true. The overwhelming majority of employers who currently offer health insurance benefits to their workers will not have to shoulder any additional burdens under the bill. In fact, they will enjoy significant cost savings by virtue of the reduction in cost-shifting among employers, the preemption of state mandated benefits laws, and the establishment of the risk pools which will be able to offer insurance coverage at more affordable rates.

As previously indicated, the UAW strongly opposes any effort to "carve out" small businesses from this legislation. This would undermine the twin objectives of promoting broader access to health care and reducing unfair cost shifting among employers. However, we are willing to explore the feasibility of tax subsidies which could be targeted at those small businesses that truly require assistance.

I would like to emphasize, Mr. Chairman, that the approach adopted by this legislation is essentially a private sector solution. The legislation basically seeks to require the private sector to step up to the responsibility of providing adequate health insurance protection to workers and their families. There is no justification for letting employers escape from this fundamental responsibility. To allow a small minority of employers to continue to evade this responsibility is unfair to the federal government, to other employers, as well as to workers and their families.

Mr. Chairman, let me conclude by stating that, as essential and commendable as this legislation is, we must all recognize that it is not a panacea for all of the health care problems facing our nation. Specifically, the bill does not address the problems associated with:

- continuing medical care inflation;
- the often inadequate and uneven quality of health care available to individuals;
- the shortages of doctors in many rural areas and inner cities;
- discrimination against the elderly, the poor, women and minorities in securing needed health services;
- shorter life spans of the poor and minorities;
- infant mortality rates in many U.S. cities comparable to those found in many Third World countries; and
- the staggering costs associated with long-term care for the elderly and disabled.

These problems can be met only by a universal and comprehensive national health plan. With the exception of South Africa, the United States is the only industrialized nation without a national health plan. Individuals in Canada, Great Britain, Sweden, West Germany, Italy and other countries are guaranteed basic health care protection by law. American citizens should also have this same protection by law as a basic social right.

As you know, Mr. Chairman, my predecessors as President of the UAW have been leaders in the fight for a national health insurance program. I remain committed to this struggle, and I am confident that it will be won. Although that objective continues unchanged, we recognize that we have an opportunity at the present time to begin to promote greater access to health care. That is why the UAW is committed to work in support of the legislation you have introduced, which would at least assure access to basic health care services for all working Americans and their families.

Again, Mr. Chairman, the UAW applauds the leadership that you are providing in the effort to expand access to health care. I am enormously pleased to note that we are once again talking about making social progress in this country - about taking public action against serious national problems that individuals may be powerless to overcome. In recent years, we often have had to struggle simply to hang on to past gains. I believe that Washington is beginning to realize that the American people are eager to go forward again. This legislation can be an important part of the response.

We look forward to working with you, Mr. Chairman, as H.R. 4951 moves forward in the legislative process. We urge the Members of this Subcommittee and the Congress to give this legislation favorable consideration.

Thank you.

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Chairman **Stark**. Thank you very much.

I had some questions regarding the issues of helping small businesses and competitiveness. But it seems to me that what we are basically talking about here is the level of deductibles and the cost per hour. We think that our benefits would cost 45 cents an hour. I think that is fairly linear. If we wanted to bring that up to 75 cents an hour, we could get the deductible down.

Also, we don't have any copayers which, on a first-dollar coverage, would probably allow us to trade off small copays and reduce the deductible.

My question is—and maybe you would like to have your staff think about this and get back to us—should we start to think about some copay as an alternative to deductibles?

I would be interested to know what your feelings are on this.

Mr. **Bieber**. Mr. Chairman, it is like choosing between two children. I am not prepared this morning to set a priority, I guess.

The problem that we have facing us here, many of the people we are talking about covering here are people who come from low-wage industries. I must tell you very honestly that copays are a terrible burden for them. In many of these industries it is a single wage earner, and even if it is a dual wage earner it is really dual misery because the other spouse is also working in a low-paying industry.

Deductibles or copays are very much of a problem for a family such as that.

Chairman **Stark**. You lead me right into my next issue, our current discussion of the minimum wage. I suspect, as you do, that the minimum wage level, or close to it, is where we have most of the uninsured workers.

I guess this is as much a political question as it is a technical question, but do we lose anything by joining the issues?

Politically, let's suppose I could get a lot of my Republican friends and my more conservative Democratic friends to vote for a dollar. What if we said we'd make 50 cents of that $1 minimum health benefits. So if you are already providing decent health benefits, you really only have to go up 50 cents. You might want the numbers higher. But do you see any real dangers? If you are going to raise the minimum wage, why not put in the benefits at the same time? How would labor feel about our joining the issues?

Mr. **Bieber**. At the same time, but if you are asking me at the expense of increasing minimum wage, I have to tell you that that is not an acceptable alternative.

We are talking here, Mr. Chairman, of people in today's world making $3.35 an hour, a minimum wage which has not been raised for a good number of years, while the cost of housing and the cost of food and everything else has gone sky high.

It is a situation I think where we have to look hard for the answer of how we help these people. Therefore, we have to seek a way to increase that minimum wage substantially and to provide some basic medical help for them as well.

If you are using your example, put a buck on minimum wage and ask them to take 50 cents of that and pay it toward health care, you are right back where you are today. You have to make a hard choice: do you eat or do you get medical coverage?

Mr. Gradison in his opening statement said you might want to look at these costs, you might want to look at who really pays for them.

I want to point out that in addition to being head of the UAW, I also sit on the Chrysler board of directors. I happen to sit on the Health Care Committee on that board. So I get involved in discussions coming from a couple of different areas.

It is not that we are now forcing the cost over to those companies who do provide benefits, but the fact that the people cannot pay for their own hospitalization. They can't take advantage of the health care that you and I, thank God, can; we are also forcing these people into the highest possible cost-setting when they go into the hospital, because most of these people get treated in the emergency room of the hospital. That is absolutely the highest cost way to go.

It is very simple. Hospitals I think absorb some, but—let's not kid ourselves—not very much.

There is a good example of why we have seen this tremendous escalation in the cost of health care services as opposed to the rest of inflation in the country. It is very simple. All of us are paying for that. I tell Mr. Iococca, you have to make some hard decisions, too. I am not going to abandon that goal. Ultimately I think that is where we have to get.

It is simple now. You have to make the decision, do we pay through certain sections of the industry for what is, in effect, a minimal health care plan, or do we begin to look at this in the broad terms of where I think we have to get?

I think the bill here is a step in that direction.

Chairman STARK. On the minimum wage you are, at least with reference to the Chair, preaching to the choir. I have long since learned that great comprehensive bills generally are built one sentence at a time.

We are going to hear testimony later today from the $5 an hour person who claims this is going to raise my costs 10 percent and that if you do that after I have been only making a 3-percent profit, we will go broke.

You will also hear that when you talk about the dollar or so increase in the minimum wage, that labor costs will be increased by 30 percent. I suspect your workers are not going to be benefited from the increase in the minimum wage. I suppose you could make a case at the very low end of the scale, the very marginal employers, that to go from $5 to $7 an hour all at once might cause some disruption and so you would have to phase it in over time.

Maybe instead of $1.50 an hour, we could go to $1 cash and 50 cents in benefits. We will have to sell this to the guy running the filling station and he will talk to everyone; when he pumps gas, he pumps propaganda in their ear.

We have to find out how not to disrupt the economy or break the small businesses. I guess we are going to have to make these choices among our favorite children as we come down the line. It is going to be important that organized labor and organized business help us in that direction.

We are getting the support. We are getting the support from many of the industries that have bargain plans and obviously from those people who are already covered. But we are going to hear from a lot of people.

I am suggesting we are going to have to put everything together. Can we, as far as you are concerned, just talk about so much an hour? That is a long-winded way around the barn. Whether it is copays or deductibles or minimum benefits, aren't we saying how much can we push on the industries and the low-paid workers?

Mr. **Bieber**. Mr. Chairman, first of all, everyone has to understand that within my union, the UAW, it is not only the workers at General Motors, Ford, Chrysler and some aerospace companies; we have workers in very low-paying industries. We have expanded the areas in which we organize today for the last 4, 5, or 6 years.

All the people in auto parts plants don't receive those high wages and they don't have these benefits. It is a matter of dealing with that broad spectrum. I have to do that every time I sit at the bargaining table.

When I go to Ford or Chrysler, they explain to me all the costs. When you talk about copays, I guess in a sense it could be argued that when we sit at the bargaining table we are making payment. It all comes out of the pie, so to speak.

They express to me the costs for those insurance packages and the costs they have to pick up. They say, look, I am carrying this whole family, the wife or husband may be working somewhere else and we are picking up this whole piece. So we get that coming and going.

I want to point out that also when you talk in terms of General Motors, I am dealing there with a parts industry as well within General Motors. I remember down in Indiana in the Delco operation, we are dealing with parts where a half cent on that part is the difference between whether or not we keep that operation.

I want everybody to understand this is not the case of a president of a union that has all these benefits coming here. All UAW members don't have such benefits.

I think the only other way to answer your question, sir, is to say that we don't have to do all the mandates at the same time. I think it is reasonable to phase in mandates over a period of time. Maybe we need to look at it. I suppose there are some of these small businesses that are walking a tight line—but I also would point out there are many who are not providing health care benefits who are making a lot of money, too.

If we are faced with that kind of a situation, then maybe we have to look at some way to assist these unprofitable small employers through the state policies or something.

I must confess, I don't have all the mechanics at my fingertips either. The people here with me today are hearing the same questions as I am. We will be happy to go back to the drawing board, so to speak, and I can assure you if we find any good answers to any of these tough questions, we will be happy to share them with you.

Chairman **Stark**. Thank you. Your staff has been very accommodating in the past. We look forward to working with them in the future to try to make some real progress on this issue.

Mr. Gradison.

Mr. **Gradison**. Thank you.

The discussion you had was excellent. It brings out the concerns many of us have. If we move the minimum wage to $5.05, which is the proposal, and add the equivalent of the Massachusetts health plan, which is $760 a year in 1992 and a lot more than 80 cents if it is less than full time, we will be moving from $3.35 currently to $5.85. That is a big hit—no matter how you define it—to take at one time.

I have been studying the Massachusetts plan to try to understand it. Just looking at the numbers, it is easy to see what the concerns of some of the smaller businesses might be.

You mentioned a filling station. A filling station operator in the State of Massachusetts in 1992 who has more than five employees is going to provide a health plan or pay the State $10,000 a year—that is, $1,760 times six. That is a lot of money for somebody who is trying to keep the gas station going in a highly competitive market.

I have mentioned that to indicate the choices which all of us have.

Mr. Bieber, you quite properly mentioned you are reluctant to choose between two children. Having eight children, I am particularly sensitive to it.

Mr. **Bieber**. I have five.

Mr. **Gradison**. I am with you.

We have been holding hearings on long-term care which, depending on how you do it, is a $20 or $60 billion project, probably closer to $50 billion. It is theoretically possible for Congress to move on the uninsured and long-term care, but the history of how health legislation has been written makes that unlikely, to say the least.

You may not be in a position to answer it, but we get paid to make impossible choices like that, and any input you have with regard to this question I think is important. My sense is that the political push is not in the uninsured area, it is in the long-term care area, because of the high level of organization of the elderly.

Yet when I see the impact of the payment policies of Government and business and everybody else in trying to minimize cost shifting, and I look at the health care system, I must say I get more worried if I don't look at the health uninsured. That is not to say long-term health care is not an important issue.

Any thoughts you might have on this would be more than welcome.

Mr. **Bieber**. In the case of the long-term health care, as you probably are aware, in the major auto negotiations that we kicked off with Ford and General Motors last year and carried over to Chrysler this year, we have established now a pilot program of long-term health care. I don't know what questions that is going to answer for us. I suspect some.

We are going to put that program in. It will be a toe in the door—I guess that is the best description. We are going to see what comes from that during the next 3 years obviously before we go back to that table. We are still working on the implementation of it now.

I assure you we will be very happy to share with all of you whatever we find out about that program. I know this is a tremendous problem.

My mother passed away 2 years ago. She required quite a period of care before she passed on. So I know it is a very expensive burden on the family.

I guess when we get quickly to that same point that I seem to get to at every discussion we have on this matter—that is, when you get all done with it—it just points, I think, more and more arrows to the point where we finally have to get to. I am one who would advocate getting there sooner rather than later, even though I know it is costly.

I don't know how you get the answers to all these problems without finally getting to a national health plan. It seems to me that is what we are talking about. I realize the difficulty. I am faced with this every day. When I go to a bargaining table, you pose the same questions that employers pose to me. It is not easy.

We talk about the small business people. I suppose there are a lot of ways you can talk about that, target attack, subsidies, a whole lot of things. I think that ultimately we have to recognize that we are going to have to seriously look at raising some revenue and spreading this across the entire populus. I don't know how else you do it.

I appreciate the problems you have. If I had an easy answer to those tough questions that you are posing, you would have gotten it a long time ago.

Mr. **Gradison**. I am bringing it up to get your sympathy for the committee.

Mr. **Bieber**. You have it.

Mr. **Gradison**. You mentioned with regard to collective bargaining, when health and other things are on the table, I think your phrase was "it all comes out of the same pie."

Mr. **Bieber**. That is the expression.

Mr. **Gradison**. In thinking of your organization—because I know you have some outstanding economists who work with you on questions like this—who does pay these mandated benefits?

There are three main ways. One is a relative reduction over time in the cash wage in the sense that a mandated benefit is substituted. Some will think that is an important part, others will say it comes out of profits and a third group will say it comes out of the increased price passed on to the customer.

Do you have any sense of who pays the benefits in the long run?

Mr. **Bieber**. Yes. The point is being made to me that we are already paying all of these through our collective bargaining agreements.

Let me say this. If you looked, for instance, in the auto industry, if you saw the figures that I saw a few weeks ago when a report was given on General Motors, you see a productivity increase of 16.7 percent over the last year. That is an enormous increase in productivity. That is basically true of the auto industry.

I have been making those speeches for a number of years. I am proud that our workers are a part of that, where we have had the highest growth of productivity of, I think, anyplace in the world.

So obviously you have to say that some of that money that pays for these benefits comes out of that increased productivity. Therefore, it should not reflect on decreased profits for the organization or increased costs to the customer. One would hope that that was always the way things worked. On the other hand, I know that that is not necessarily true in every case.

But I guess we could go back again and say aren't we all, all of us assembled in this room today, already paying for these costs in one way or another?

These people have to be taken care of who don't have insurance. Somehow we are paying that. I guess I would like to come from the side of the argument to say if we were able to make health care available to every American, then we could assume that they will avail themselves to the modern medicine, thank God, that we have been able to put together here in this country. If that were true, the argument is there to be made, because the facts are there, then you reduce the overall costs to society because people avail themselves of the techniques that are available before it becomes a crisis situation.

It is like the dog trying to catch his tail, as the old saying goes. But I point out again, we are already paying for this. Somebody has to pay for it.

What is happening now is that those employers who provide the health care benefits literally are subsidizing those who do not.

Mr. **Gradison**. Thank you very much. I really appreciate your testimony.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Thank you.

Welcome.

On page 5 of your testimony you discussed cost shifting of trained employers in the industrial sector and the service and other sectors. It seems to me that is a very cogent point.

Maybe there have been studies I am unaware of, Mr. Chairman. We ought to take a hard look at this.

As we have said in other instances, somebody is paying for the health care, or people aren't receiving it when they very much need it. Clearly there is a lot of cost shifting.

For example, do you have any idea within your own ranks how much cost shifting there is? Have you done any studies? Maybe I should have seen it, but I am not aware of it.

For example, do you have any idea how many members have spouses who work in uncovered health situations?

Mr. **Bieber**. It is terrible, because this is my Congressman—it is terrible, I am going to shift that over to Bill Hoffman.

I should point out that Bill is also within his district, so we are keeping it within the district.

Mr. **Hoffman**. That is correct.

Congressman, we do not have a specific detail on each of the contracts. We have over 2,000 contracts.

We have talked about it with the folks who go to the bargaining table on health benefits, both sides. We figure on a national basis that it is at least 5 percent of premium dollar.

That varies on location. So if you had a small industrial complex surrounded by a service complex, you would have a higher percentage than that.

It varies across the country by location and by concentration of heavy manufacturing versus location of the service based industry.

Again it is impressionistic on this level. However, at every bargaining table we have been in the last 10 years the issue has with increasing impetus been raised by employers that we find ways of dealing with the lack of coverage elsewhere by dependents, where other employers are not standing up to their fair share and taking on the responsibility.

Mr. BIEBER. I might just add this, as I think most of you are aware. I think you certainly are, Congressman. We have done a great deal of work with Chrysler and General Motors and Ford.

It really started with Chrysler. We have worked very closely. Bill's department and the UAW with the Chrysler people.

We were able to ring out, you know, some costs in there. All of that has been done now. I hear about this directly from the top people of the corporations screaming about how much it is costing them to take care of other people's liabilities. And I have to tell you that when you see the increase in that cost, and you see it also a direct parallel with the unemployment and the loss of people from industry where they have health care benefits now going into other industries where they don't receive benefits, you see the cost of Chrysler, General Motors and Ford escalating. And you know—and they make the argument that a big piece of that is simply because you are shifting those workers onto the spouse and dependent coverage that we have. That is a difficult burden.

Mr. LEVIN. Let me ask you if your excellent research department could send us any information. Perhaps our staff could take a look at this. It is a critical area.

We are talking about American competitiveness. And I think instead of a lot of rhetoric going back and forth, we might do some disaggregating.

Mr. BIEBER. What we will do is this. We will run our own figures on it, and we will ask the major companies, especially GM, Ford and Chrysler, to give you their figures as well. I know that they run figures. I think it would be interesting to look at that.

I must tell you again because I also sat on the Chrysler health care subcommittee, I can't argue the point when that that is not correct. It is there. I see the figures.

I know that when you just look at the years in which the employment in the basic industry, in this case the auto industry, has gone down, those costs have shot up. If you look at the percentage in increase in health care, we all know if it was just the hospital administrators, if it was just them willy-nilly raising those prices, obviously, we have meetings with those people, too, within our communities.

It is a direct correlation there with the fact that people have lost jobs where they had benefits. What they do, they come in now on these, the programs that are there to pay for them.

Mr. LEVIN. Thank you.

You also make reference to mental health benefits in your testimony. I am glad that you did that.

One other quick note. You, with your usual generosity, recognized the contributions of your predecessors. This has been a long battle for the UAW in a societal way.

In a sense it can be argued that UAW would be better off without a mandated system because it is an incentive in organizing, I would think, that you can bring health benefits for those who join the union.

Your longstanding interest in this issue, I think, is a tribute to the community involvement and interest of the UAW.

Thank you very much.

Chairman **Stark**. Mr. Anthony.

Mr. **Anthony**. Thank you, Mr. Chairman.

I appreciate the witness' testimony. Inasmuch as this particular subcommittee and the full committee is comprised of Members from a wide range of districts that have different make up, I would like to share with you a perspective from a district that I represent.

All rural hospitals, have difficulty in securing good doctors in rural areas. I don't care if you go to the best health insurance that can be offered in the marketplace, for some reasons the doctors want to live in Little Rock, not Eudora.

For some reason all the hospitals are built in Little Rock. They don't want to go into Lewisville.

I have about eight in the process of going out of business. I have two that have already closed.

As we talk about not only mandated benefits, but catastrophic health—the drug bill, as we are going to learn to deal with those costs and all of these other costs—I guess if there is any one thing I could encourage anybody who represents a large union principally located in the midwest is to also have your committee take a look at what these costs would do to a rural state, a capital-poor State and for Members who represent the rural areas in terms of whether or not there will be continued displacement of the medical services provided to the people who reside in these rural areas.

Otherwise you are going to have a difficult time getting my vote or my enthusiasm on the subject matter.

Mr. Chairman, if moving to long-term care and mandated health benefits is going to be anything like the battle we struggled with in the subcommittee just to do catastrophic health, I think we will all agree that we are in for a tough battle. We went through about 15 days of the toughest markup I have been involved in since I was elected 10 years ago.

On one occasion I think I even made the chairman break his gavel.

The point being this, I don't think there is any question but the empirical data shows we have a lot of people being uncovered. I think we need to establish policy to see to it that these people get covered.

At the same time, we can't run the small business out of business in order to comply with any overall public policy.

I would like to congratulate you on the fact that you have been working with some of the major corporations to set up some good model programs. It may be the corporation shown from the business community, the labor community, the health community and the politics in Massachusetts, maybe we can learn from that example in terms of how we can develop a consensus for this important program in the future.

I don't think we will be able to get any legislation out of the subcommittee if there is not a broad consensus out there among all of the affected parties. Otherwise, I think you will get bogged down in the nitty-gritty votes in terms of who represents who in these areas.

I just want the record to be complete that somebody is speaking up for the smaller, more underserved areas in this country.

Mr. **Bieber**. If I might, Mr. Chairman, just say this to Congressman Anthony, I appreciate your point. I must tell you that I was born and raised and grew up in a very small, rural area. Sandy Levin ran for Governor twice in the State, and he never found the little town I was born and raised in.

It is true, about 20 houses made up the whole little community.

In addition, I served on the West Michigan Comprehensive Health Commission before I came to Detroit. I thoroughly understand the problems of the rural area and the problems of the small hospitals and the problem of being able to attract doctors.

If you are fortunate enough to live in Petosky, Michigan, you don't have problems getting doctors to come there. It is a small area, but a beautiful place to live. It is an exception.

Seriously, I do understand that problem. I guess I would want to say once again—and I do represent some people in your district as well, that I realize that. Again, I just think it goes to my point earlier.

I don't want to keep whipping that this morning. But I think all of these things that we discuss here just have to heighten awareness.

I think the American people are coming more and more to that consensus that what we need to look at is a national health plan. I see that as a way of also trying to relieve some of these situations.

I think there ought to be such a plan, incentives to doctors to practice in rural areas. I think you have to take those things into consideration.

It is one way of attracting them. I recognize the little town that I came from. We had a little country doctor, a good doctor.

You know, it was much more attractive for him to make off to the big city where the money was better and the conditions were better. And I think we need to look seriously at a plan for distribution of hospitals in rural areas and take into consideration that these may be things where you have to do some special things to help them.

I can't separate that part of the argument from my other part. That is I think that people in the rural areas are entitled to the best medical benefits and availability of those modern medicines and techniques as well as I am when I live in Detroit or some other big city. I am very cognizant of that. I appreciate that point.

Chairman **Stark**. Thank you very much, Mr. Bieber, for your presentation.

I thank you in advance for the help you know I am going to need from your staff and associates as we work on this problem.

Mr. **Bieber**. Thank you for having me.

I will make sure that we try to get you some of the material you asked for.

Chairman **Stark**. Our next witness is Prof. Robert J. Blendon, chairman of the Department of Health Policy and Management at the Harvard University School of Public Health.

Welcome to the committee.

We have a prepared statement which without objection will appear in the record.

STATEMENT OF ROBERT J. BLENDON, SC.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Mr. **Blendon**. First, the chairman and Mr. Gradison covered every point in my statement. My purpose was to come here and define the problem. I think you guys got this without my coming down.

Let me just put a few facts for the audience into this. Then the one message I want to leave people with, which is actually Congressman Gradison's, there are a number of things going on independently in the country which are likely to make this problem worse, which are not as visible to people as they might be.

I am going to try to check them off.

First, let me just review the issues. What I am relying on heavily is a UCLA-Robert Wood Johnson Foundation national survey of the problems Americans face in gaining care.

The first conclusion is that most Americans have health insurance. They report they have very few problems getting care.

When you get to the uninsured, you are in a different ball game. I want to cover this mostly because when you survey the average American, Americans believe that we have a safety net in this country which consists of public hospitals, voluntary hospitals, and free care in public clinics.

In the public's mind, that is how we deal with this problem. What this survey finds for people who are uninsured is that there are two kinds of uninsured.

There are the people who end up getting uncompensated care and are a serious problem. Then there are Americans that never get the care.

Let me summarize the dramatic pieces of this.

If you have 100 people over here who say they are ill and are uninsured, and 100 over here that say they are ill and are insured, the uninsured will see a doctor 40 percent less often. If you have 100 kids that are uninsured and 100 with insurance, those without see doctors 35 percent less frequently.

Because people will sometimes say they don't need care, we had a panel of 100 doctors pick symptoms that they believed as doctors should require a doctor's care—pain in the chest while exercising, unexplained bleeding, fainting frequently—kinds of things that common sense would say to see a doctor. The results are most dramatic: given 100 people without insurance and 100 people with insurance. The majority of those with a symptom who have insurance will see a doctor. The majority of those without insurance will not see a doctor.

The idea that people who have pain in chest while exercising get uncompensated care is over done. A share of them never show up.

It is from this survey that we found the question reporters keep asking, "Aren't they smart enough to go off and get free care?"

The answer is that 1 million people on the survey went out to a hospital or doctor and were refused care for financial reasons.

Chairman **Stark**. What happens when someone with chest pain keels over and the ambulance is called?

Mr. **Blendon**. The answer looks like in that case you get in somewhere. But the one stage before, that is I have the pain and I don't go in to get looked at, and I hope that it is a minor infraction, there is a significant reduction.

For kids it is quite dramatic. Either parents are afraid to ask for uncompensated care or they are treated badly in getting it, but basically low-income kids without insurance do not end up in doctors' offices at the same rate as those with it.

Let me just mention some of the obvious reasons with this committee and then a few of the nonobvious.

The first is everybody believes somebody has a public hospital to take care of them. The point we have to recall, one third of the cities in this country have no public hospital. There is no Philadelphia General left.

Second, the question of insurance. In 1974, when this heated up before this committee, a number of people testified and said to this committee, "Don't worry, private sector alone can solve this problem." We have 25 percent fewer people with insurance than in 1980.

We have less of our low-income population covered by Medicare today than in 1975. For a variety of reasons dealing with the economy in States we are moving totally in the other direction.

Coupled with that is private giving. In 1970, $4.50 out of every $100 was private philanthropic giving. Today it is $2.50. One of the Congressman told me that St. Louis people can raise the money to give to kids. The money isn't there from the charitable fundraising. We all say "thank God they can raise it from the charity ball." They are not able to raise it the way they used to.

The last reason has to do with the point you covered. We have an unofficial agreement in this country across business and labor. That is they would permit a certain amount to be tacked on their bill, to cross subsidize insurance. Through commercials we used to call it charges.

Across this country now you meet with union leaders and business leaders that say they have renegotiated that out of their contracts, that they are paying for their people alone. If I am running a hospital today in rural or urban America, I don't have the philanthropic base, I have got more uninsured than I had before. I have got business and labor groups saying this is a terrible problem in my community, but you can't get me to pay for it. These are all going independently. Nobody comes to Washington and says they are going to give less philanthropically. Each makes this decision.

When a mayor closes the public hospital, it is to a national issue, except there is nobody there to see the patients. We can take this data any place that the committee would like.

[The statement and attachments follow:]

Testimony by Robert J. Blendon, Sc.D.,
Harvard University School of Public Health, before the
House Ways and Means Committee, Washington, D.C.

Mr. Chairman, I would like to thank you for inviting me to testify today. My name is Robert Blendon, Sc.D. Currently, I am professor and chairman of the Department of Health Policy and Management of the Harvard School of Public Health. In addition, I serve as Deputy Director of Harvard University's Division of Health Policy Education and Research. Prior to this appointment I served as Senior Vice President of the Robert Wood Johnson Foundation in Princeton, New Jersey.

As members of this committee recognize, health care in 1988 is vastly different than it was a decade ago. An aging population, the looming physician surplus, the emergence of large multi-hospital corporations, the growth of Health Maintenance Organizations, the commercialization of medicine, new systems for paying our hospitals, technological advances, and a plethora of new outpatient treatment facilities are forcing changes in our health care system.

Congressmen invited to speak to civic, business, religious, and professional groups about health care quickly discover that many of these organizations have very differing views on these new health care directions. On one hand, some strongly believe that this is going to be "the Golden Age of American health care" -- more competition, lower hospital charges, more available doctors, the return of house calls, the introduction of "sound" business management practices, and new but adequate local arrangements for providing medical care to the nation's poor and uninsured. Others, looking at the same "crystal ball," see a future of "cut-throat competition" leading to a decline in the quality of the nation's medical care, doctors and hospitals advertising and providing unnecessary and expensive medical procedures, and millions of those who are uninsured turned away from needed medical care by "business-like" health care institutions because of inability to pay.

Over the coming decade, The Congress will increasingly be confronted by these very polarized positions -- one set of constituents seeing these many changes leading to dramatic improvements in our health care system, while others see pending "national disaster." The reality is that this issue is not settled. Many of these rapidly unfolding changes are just beginning.

One of the most commonly asked questions about this changing environment is: Do all Americans have access to needed health care regardless of their ability to pay? Surveys show that Americans are almost unanimous (82%) in their support and concern for this principle.[1]

My testimony will attempt to answer this question briefly and simply. It relies on a number of data sources but most importantly on the 1986 UCLA-Robert Wood Johnson national survey of Access to Health Care (see appendix 1). My conclusions which I will describe in greater detail are as follows:

1. Most Americans who have health insurance report few difficulties in obtaining access to health care.

2. However, Americans without health insurance report major barriers to obtaining needed medical care.

3. America's "safety net" for those who are uninsured appears to be unravelling.

4. America's leadership groups are still struggling to find a consensus on how to resolve this problem.

1. Most Americans who have health insurance report few difficulties in obtaining access to health care. Nearly nine out of ten insured persons say that they did not have problems in obtaining the medical or surgical care they needed. A similar proportion report they had a regular source of medical care, be it a physician, hospital, HMO, etc., and they were satisfied with their last experience with it.[2,3,4]

2. However, Americans without health insurance report major barriers to obtaining needed medical care. Even though our country's hospitals now provide nearly ten billion dollars a year of uncompensated care, national studies continue to show a wide disparity between the ability of the uninsured and the insured to obtain health services.[2,3,4] The UCLA - Robert Wood Johnson study describes this worrisome situation. As shown in Exhibits 1 and 2, people under the age of sixty-five without health insurance, although generally less healthy than their insured counterparts, saw physicians 27% less frequently and were hospitalized 19% less often. Similarly, this figure was 34% less for visits to physicians by uninsured children. In addition, the study found the general gap in receipt of physician care was widest for those who were in the most ill health (Exhibit 3). Those uninsured who described themselves as being in fair or poor health reported 40% fewer visits to a doctor than those with health insurance.

An estimated one million Americans reported that they actually tried to obtain needed medical care but were refused by doctors or hospitals for financial reasons. Similarly, an estimated 13.5 million Americans stated they were not able to obtain needed medical care because they did not have adequate economic resources. The majority of Americans experiencing these difficulties were uninsured or poor. In a finding equally as dramatic, the survey indicates that people without health insurance saw physicians 50% less often for symptoms of serious illness than those who were insured. The symptoms, judged by a panel of physicians to warrant seeing a doctor, included unexplained bleeding, periodic loss of consciousness or fainting, and chest pain when exercising.[2,3]

The large proportion of pregnant women who did not seek prenatal care in the first three months of their pregnancy is especially troubling. A recent Institute of Medicine study concluded that early prenatal care leads to improved maternal and infant outcomes.[5] However, although infant mortality in the United States has been reduced by half since 1970, the rates of infant death in this country still exceed those of many other comparable industrialized countries.[6] It is therefore of concern to find one in five uninsured pregnant women surveyed in 1986 did not seek medical care early in their pregnancies (Exhibit 4).[2,3]

Such barriers to care appear to be affecting the health of our young infants, both Black and White. As shown in Exhibit 5, our neighbor Canada, with similar medical knowledge, professional skills, and technologies, has been reducing its infant death rate at a faster rate than the U.S. In the last decade the Canadian rate fell 41% while the U.S. rate declined only 32%.[6,7]

These studies suggest that as a result of Medicare and Medicaid, to be poor in America is no longer a major deterrent to obtaining adequate health care.[8,9] But to be uninsured is! To be both uninsured and poor remains the most serious problem of all.

3. **America's "safety net" for those who are uninsured appears to be unravelling.** Over the years, the United States has gradually adopted a three-track system of health care financing. The first track has been private health insurance for employees and their families. The second is public insurance for the poor on welfare rolls, the disabled, and the retired. The third is a system of governmentally subsidized public hospitals and neighborhood health centers, coupled with a major commitment of more than six thousand philanthropically supported non-profit hospitals, that provide free or subsidized care to the poor who are not on welfare or to the uninsured. This three-track system appears to be breaking down. A number of forces are at work here:

- Private sector concerns with economic conditions and competitiveness have led since 1980 to a 25% increase in the proportion of Americans without health insurance (Exhibit 6).[*] Thus we see nearly two-thirds of the 37 million uninsured (62%) are in families with an adult currently holding a job, but without health insurance coverage.[10,11]

- Fiscal pressures on federal and state governments have resulted in a decline since 1975 in the proportion of the nation's poor and near-poor covered by Medicaid (Exhibit 7).[12,13]

- Real growth in philanthropic spending in health care has declined from 4.6% of national health expenditures in 1970 to 2.7% today. Real private giving is now a smaller source of revenues for the charity care offered by non-profit voluntary institutions.[14,15]

- The amount of "free care" provided by voluntary hospitals is not sufficient to meet the growing proportion of uninsured in the communities they serve. Communities that have no municipal hospital are encountering additional difficulties. Today one-third of the nation's hundred largest cities have no public free care institution and the poor must depend on non-profit hospitals for uncompensated care.[16]

- One of the indirect mechanisms by which the nation has financed care for the poor is rapidly changing. Historically, middle-class Americans have overpaid for their health care services, and these overpayments have subsidized care for the poor. However, in the face of rising health care costs, many private business and union health insurance policies prohibit the shift of the costs of medical care for the poor to their members policies. This phenomena has been encouraged indirectly by the ERISA pension legislation.

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[*] Differing surveys continue to show some variation in the proportion of Americans who are uninsured. CPS data are utilized here because they provide a continuing time series.[4]

These trends, when viewed together, suggest that the question of who will pay for the care of the uninsured is becoming a critical health care issue for the nation.

4. America's leadership groups are still struggling to find a consensus on how to resolve this problem. Having spoken to more than a 100 private and public sector groups about this issue, I recognize how difficult it remains to agree on a solution. Leaders in all walks of life -- Governors, state legislators, medical society presidents, insurance and health care executives, hospital administrators, foundation presidents, Mayors, etc. -- all agree that it is essential that someone pay for the health care of those who are uninsured. Their one caveat: it can't be them alone! Clearly it will require strong leadership from the Congress if a national consensus on resolving this dilemma is to be found.

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APPENDIX I

THE UCLA-ROBERT WOOD JOHNSON FOUNDATION
ACCESS TO CARE STUDY

Conducted by
Howard Freeman, Ph.D.
Chairman of Sociology, UCLA

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Technical Appendix

Survey Design: The survey was designed to collect data from a randomly selected sample of people representative of adults and children in the United States. Data were gathered through telephone interviews of adults and through proxy interviews with a parent for children under 17. To measure the effects of omitting households without telephones, a separate probability sample of 300 such households was selected in three sites.

All computations used in the text and charts are based on weighted distributions to correct for oversampling of the chronically ill and some other groups and to allow estimates to be made for the total noninstitutionalized population of the United States.

10,130 people in the continental United States were interviewed from the spring through the fall of 1986, the same time of year during which interviews were conducted for the 1982 access survey. Interviews were conducted in English or Spanish.

When a household was reached through the random-digit dialing methods employed, a screening interview was conducted with an adult member of the household. Questions were asked about the conditions used to define illness and a household listing was completed. The computer then selected at random the household member(s) to be interviewed. If the randomly selected respondent was at home, the interview began immediately. Otherwise, the interviewer attempted to find a convenient time to call back.

At the end of the interview with the randomly selected adult, this individual was asked whether any family members had any chronic or serious illness or other health problem that prevented work, school, keeping house, or carrying out normal activities. If a sick adult or child was identified, that person or a proxy was subsequently contacted for an interview.[11]

Data were collected from telephone center locations at the Urbana and Chicago offices of the Survey Research Laboratory, University of Illinois, and the Madison office of the Wisconsin Survey Research Laboratory, University of Wisconsin. In order to ensure that identical methods were used, all training was conducted by the same field coordinator who had also prepared the training material. The completion rate for individuals selected for interview was 76 percent.

Previous Surveys: The 1986 survey is the seventh in a series of national household surveys of access to health care. The first five were conducted by the Center for Health Administration Studies of the University of Chicago. The sixth was conducted by Louis Harris and Associates, Inc., with secondary analyses carried out by the Center for Health Administration Studies.

Some Definitions: Poor: The poor category is defined as below 150 percent of the poverty level established by federal guidelines. Determination of poverty level conforms to a Social Security Administration index and is based on family size and total family income, excluding the value of noncash benefits such as Medicaid.

Whites: Non-Hispanic Caucasians, Asians, Alaskan Eskimos, native Americans, and other except blacks.

Urban/Rural: The urban category corresponds to Standard Metropolitan Statistical Areas, or central city and suburban areas. Rural includes non-SMSA rural and farm areas.

Uninsured: The uninsured are those who did not have coverage under a health maintenance organization, Medicare, Medicaid, other government health insurance, self-paid health insurance, or employer-paid health insurance.

Chronically or Seriously Ill: People with asthma, emphysema, cancer, heart disease, stroke, high blood pressure, kidney or liver disease, diabetes, neurological disorders, mental retardation, pneumonia or influenza, serious injury, or other disabilities.

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EXHIBIT 1

Mean Number of Physician Visits, Percent Hospitalized, And Perceived Health Status By Insurance Coverage For Persons Under 65, 1986

Insurance coverage	Physician Visits	Percent in fair/poor health
Uninsured	3.2	12%
Insured	4.4	9
Gap (percent)	-27%	
	Percent hospitalized	
Uninsured	4.6	12
Insured	5.7	9
Gap (percent)	-19%	

EXHIBIT 2

Mean Number of Physician Visits By Insurance Coverage For Children Under 17, 1986

Insurance coverage	Physician Visits	Percent in fair/poor health
Uninsured Children	2.5	6.4%
Insured Children	3.8	6
Gap (percent)	-34%	

EXHIBIT 3

Mean Numbers of Physician Visits For Those Under The Age of 65 in Fair or Poor Health, 1986.

Insurance Coverage	Physician Visits
Uninsured	6
Insured	10
Gap (percent)	-40%

EXHIBIT 4

Indicators Of Potential Underuse Of Medical Care, 1986

Problem	U.S.	Uninsured
Percent with chronic illness without physician visit in a year	17%	20%
Among persons with one or more physician visits in year, percent with serious symptoms who did not see or contact a physician.	41	67
Percent pregnant women without first trimester prenatal care	15	20
Percent of Americans not receiving care for economic reasons	6	20

Exhibit 5

Infant Mortality, United States and Canada
1960 - 1986

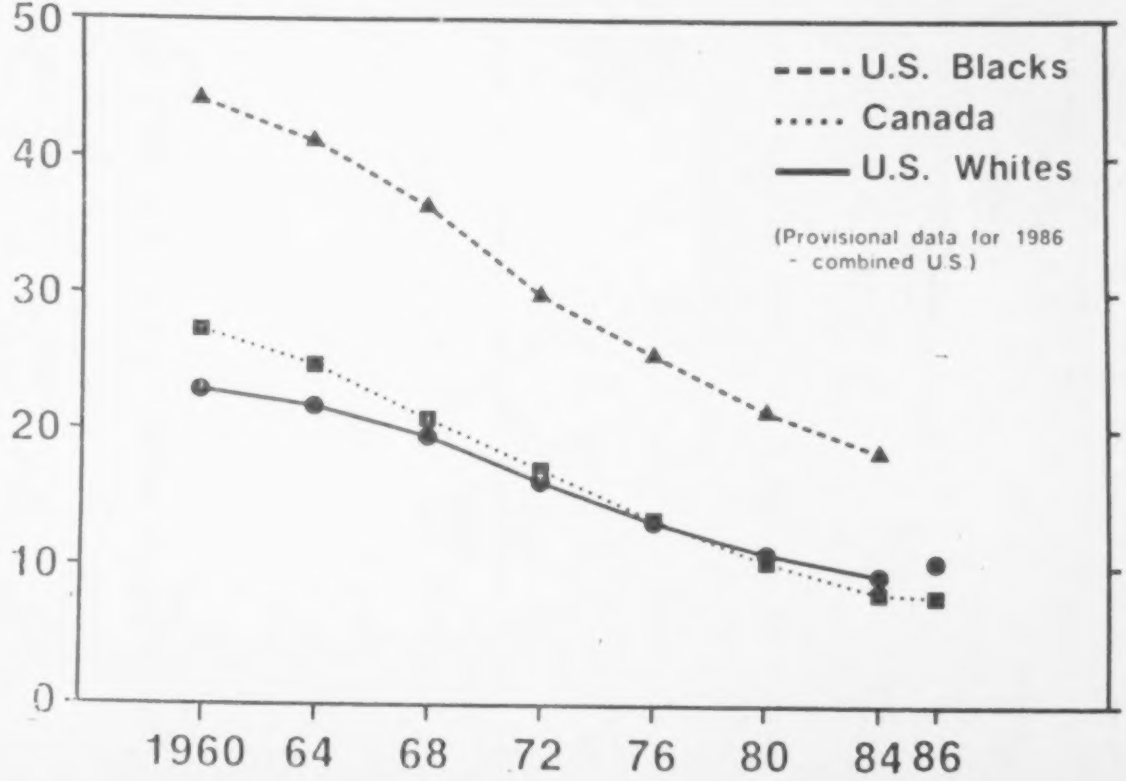
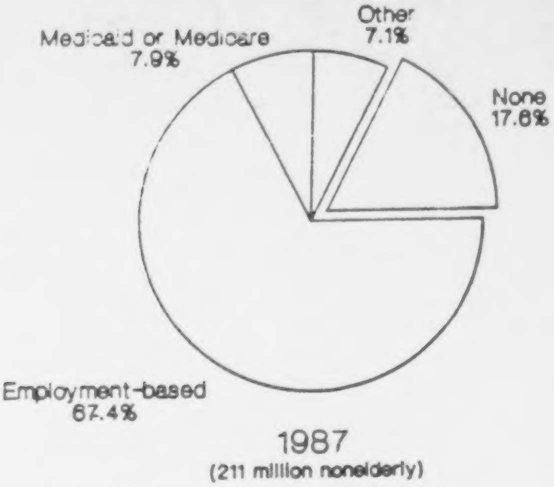
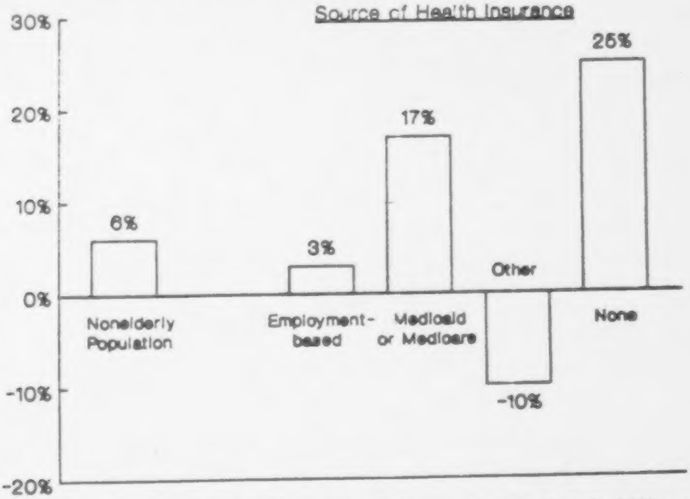


EXHIBIT 6

Sources of Health Insurance for the Nonelderly Population, 1987



Percentage Change in the Nonelderly Population and Their Sources of Health Insurance, 1980-1987

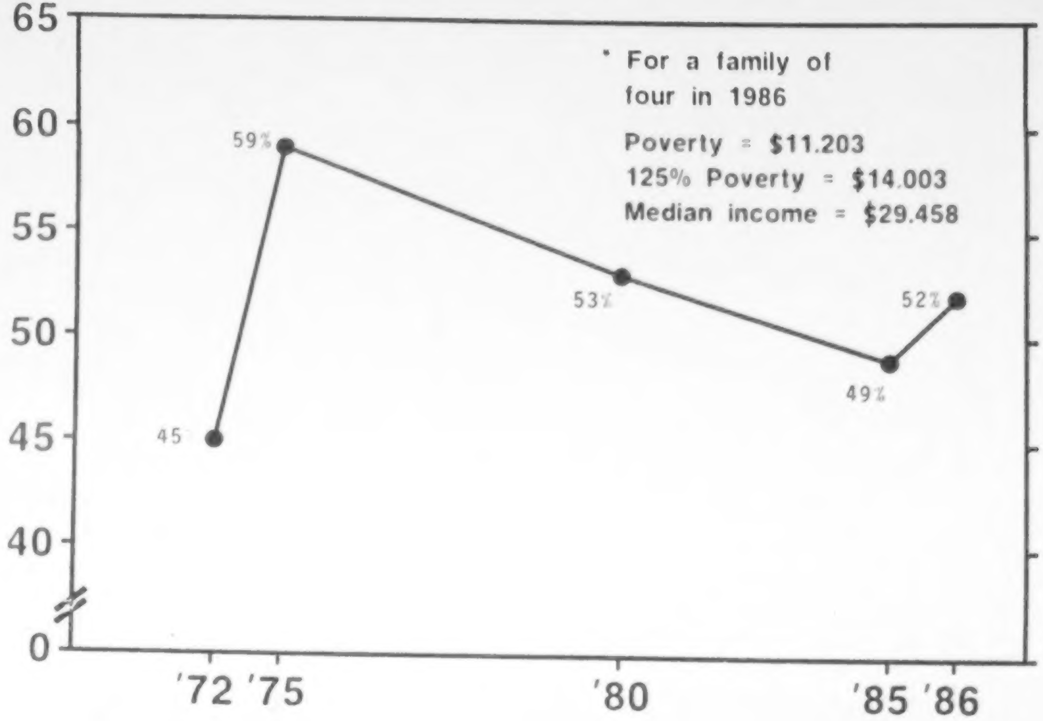


SOURCE: Congressional Budget Office tabulations of the March 1980 and March 1987 Current Population Surveys.

NOTE: The surveys ask respondents about insurance coverage during the last year. Because of recall error, however, the responses are more likely to reflect current or recent coverage. Therefore, for example, these figures assume that the March 1987 survey reflects insurance coverage in the early months of 1987.

Exhibit 7

Medicaid Recipients as a Percentage of Persons Below 125 Percent of Poverty* 1972 - 1986



* For a family of four in 1986

Poverty = $11.203
125% Poverty = $14.003
Median income = $29.458

Chairman STARK. Let me get you to jump in here. I promise we won't have a 15-day session.

Congressman Anthony brings up the issue of the problem in rural America. Mine is open.

We have a rural hospital, but it is so crowded that a lot of people are griping about the county paying so much a year in its budget to keep it going.

Are there distinct regional differences? Do some rural areas, say, in rural Maine, have excellent coverage available, and some in rural Mississippi none? Is there any pattern?

Mr. BLENDON. The answer is in the various studies which are available, there are significant regional variations. That is the South has the biggest problem in terms of uninsured. Even within communities it varies.

But in general, rural America has a poorer level insurance coverage. It also has a lower level of Medicaid coverage. If I am running a hospital in rural America I am faced by the fact I have fewer people covered by private insurance.

The dilemma is that they are likely to be working people. In rural America you have a high proportion of working people without insurance. Then I don't have any public programs to pick up with that.

Actually, having spoken to the Oklahoma Hospital Association, if we don't figure a way to deal with some of these financial problems we are at mass closures in some of these states which are highly rural concentrated.

I dealt with the issue of what is changing. It happens to impact certain states extremely hard.

Oklahoma is one of them where you have got low occupancies, and they have no financial base to fall back on.

Chairman STARK. Is it hardhearted and out of the question to think of small rural hospitals going the way of the small rural school and becoming consolidated districts with more modern transportation, or is that—understandably there is a community pride and convenience for any situation. But there may be a scale which would bring trauma centers and capital costs——

Mr. BLENDON. The answer is yes, to that. There are two problems in rural America. There is the problem of real underfinancing.

Second, and this point is a painful one to mention, we are running out of people who necessarily want to be hospitalized in rural hospitals. One of the things happening, even in states like Arkansas and California, people are driving past small rural hospitals and going into the cities.

There are a number of studies that suggest that. So in some of the communities we do not have the patient base to support those hospitals. We will have to provide alternatives.

Whether or not it is for drug treatment or long-term care, I happen to be a supporter of the idea of swing beds in rural hospitals.

The reason why people have to drive 75 miles to go to a nursing home in Little Rock when you have an empty rural hospital is not clear to me. There are alternative uses, but there are places where we don't have the patient base to support as many hospitals as we have.

But because we can't figure out a way to do anything about this, we are likely to have a whole number of them go bankrupt instead of having the equivalent of a consolidated rural school.

Chairman STARK. Final question. I have referred to the Robert Wood Johnson study off and on.

I have alluded in round figures to 1 million people who do not obtain care because they can't afford it and they are denied, and 5 or 6 million who think they can not get insurance but maybe could.

Is this generally accepted as a valid study? If you are talking about 6 or 7 million Americans who do not get care? Or am I way off base?

Mr. BLENDON. It has been—again this committee heard scientists argue with each other about the validity of studies more than I think they want to know about—it has been considered valid enough to be published in the New England Journal of Medicine. It is the only survey in the country that asks people about those problems.

We don't have the validation that people like to feel comfortable with five other surveys asking the same question.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Dr. Blendon, recognizing the problem exists, what is your recommendation to us with regard to a mandated benefits on employers?

Is that the way to go in filling—well, not for the whole gap, but in filling a substantial part of the gap?

Mr. BLENDON. Since I read the hearings in 1974, and I even brought this committee commission the whole series of reports, at that time there were 14 separate bills. My view is if any of those bills had been enacted, we would not have had this hearing today. So I am extremely humbled by this issue.

Let me tell you what my historical reading of this period is—and for the record, it was Governor Rockefeller, who some thought was running for President, who in New York State introduced the first mandated insurance bill. The bill was picked up by Richard Nixon and Senator Packwood in the early 1970's.

Congressman Mills almost thought they had a compromise bill which was listed in here ad nauseam that would have generally solved this problem. It fell apart.

During those hearings something occurred. What occurred is people like myself testified. We testified for very comprehensive benefits which were supported by health professionals.

As the benefit package grew, got further along—and I happened to endorse the most comprehensive benefit—but as it got along, the newspapers start to cover the total cost of this and the business community, many of whom were sympathetic to the idea, and Nixon, got very nervous.

My testimony on this in 1988, and the research, can be summarized as follows: Some insurance is better than no insurance.

Regardless of what people testify, it is better to be sick with a basic policy than it is to be sick in this country with no policy.

I am for a basic mandated insurance plan which would have the most minimal impact spread out over time so we do not scare the American business and working community away from this table.

But I am terrified that we will duck this issue, as Congressman Gradison is, because there are other areas on the national agenda, by trying to make this so expensive that we cannot consider it. But some insurance would absolutely help those kids get in that door.

Mr. **Gradison**. I want to thank you, first of all, for the historic reference, the reference to the history of this. I had forgotten that Richard Nixon endorsed mandated benefits in 1974 on the public record.

Mr. **Levin**. Does he in 1988?

Mr. **Gradison**. In 1974, he was President of the United States, and it didn't make a difference. But I think it says something about the resistance to the idea.

I think it makes the point that I don't think it is an issue of whether people are for or against mandated benefits. We used them in some cases and rejected them in others.

It is a question of what is proper and what you can afford.

I just want to tell you from my own experience that you are dead right about the problem with a minimum package.

You say you don't have dentist coverage. That is discrimination.

You have to have freedom of choice. You are right. If you don't have one without the other, you hear mental health people say, "Your package is kept at a certain amount."

God knows I recognize the importance of mental health programs. On you go through every specialty.

Sure they are looking out for themselves, but they are also concerned about the people they take care of.

They blow us apart by the time you had the dentist, the mental health and the chiropractors and everybody else.

There is legitimate reason for wanting them to be included. It is a real problem.

Thank you, Mr. Chairman.

Chairman **Stark**. I don't want to leave the Democrats out of this.

Carter and Califano, in 1980, also had a mandated bill that went nowhere.

Mr. **Levin**. You take equal credit for lack of progress.

Mr. **Gradison**. We are laying the basis for explaining some things in a year or two, I think.

Mr. **Levin**. Let me ask you about your statement on page 6 about the 25 percent increase in the proportion of Americans without health insurance.

I think one reason there is a bind on priorities is because, in many instances, there has been inaction.

For example, minimum wage. It has been so long since the minimum wage increased, we have this accumulated need.

The statement that you made about the proportion without health insurance leads in the same direction.

I was looking at your chart, though, the exhibit. It is the bottom one that compares 1980 versus 1987.

Please just review for us what that chart means.

Mr. **Blendon**. Well——

Mr. **Levin**. The percentage is those without insurance? Is that the left-hand side of it?

Mr. **Blendon**. The far right, if we are looking at the table where it says, "25-percent increase," where it says "none uncovered."

My apologies for the table.

In order to avoid the testimony problem of scientists disagreeing, I used the Congressional Budget Office's table.

Frankly, I would have made a simpler table. It shows 25 percent of Americans in 1980 don't have insurance.

The base line is under 65.

It is 25 percent less of the population under 65 that have an insurance card.

Mr. LEVIN. Twenty-five percent fewer?

Mr. BLENDON. Right.

Mr. LEVIN. Of those under 65, are covered by insurance?

Mr. BLENDON. Than in 1980.

Mr. LEVIN. What is the reason? What are the reasons for that?

Mr. BLENDON. All the work on this has been primarily done by Kathy Schwartz at the Urban Institute.

It is often census data. It appears after the deep recession of 1980 and 1982, many businesses did not pick up the insurance coverage for their employees.

Many people have gone to work—because the change in the economy from larger employers to smaller employers has led people to shift from covered industries to uncovered where there is less health insurance coverage.

She reports there has been a reduction in the number of insurance policies that cover the children of the workers, that after the recession, one of the ways people cut back to control their health care costs was to drop dependent coverage.

Those are the three reasons that she uses based on the census studies.

Mr. LEVIN. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

The area that I would like to see if you have done any study or if there are studies, is this growing body of evidence that less people covered.

If you are not covered, you don't go to the doctor.

Children aren't going to see the doctor, pregnant women aren't going to see the doctor.

It appears to me that we are setting ourselves up as a Nation with a great deal of hidden costs that society as a whole will end up paying for. If all these people have got to do is get eligible for Medicaid and they can get service because we do have the coverage.

Have there been any comparisons in terms of what the long-range cost would be for our neglect in this area versus what the immediate cost would be to mandate it?

Mr. BLENDON. Almost all the studies are around the problem of infant care and lack of maternal care, where there is data that it is more expensive not to provide preventive care.

Let me just mention a point that might not be as obvious to people.

I have had a chance recently to meet with people from both the South Korean Government and the Japanese Government.

You would not believe it, but when we are in the Olympics this year, they have just enacted mandated insurance coverage in South Korea. The Japanese have it.

When we had a visiting delegation, I asked them why in this competitive environment are the South Koreans worried about mandated insurance coverage.

They happened to take your point. Their point was they are very concerned about investing in the long-term quality of their work force, and though they are willing to compete with us on wages and everything else, they think it makes no sense not to invest in the health and education of their kids.

When you do business in South Korea, starting in 1991, you are going to have to cover your children.

You are going to have to do it in Japan. Their argument is this long-term argument, that they have to invest in the quality of their work force.

Even though you save money today by not offering kids health insurance, you don't save money when they turn out to be adults and they are not functional in the labor market.

Almost every one of our competitors has concluded that long term it makes no sense to not educate your kids and not have them healthy when they enter the work force.

We are the only ones that say, "Let's drop the kids from coverage because it is a cheap way to compete with the South Koreans."

The South Koreans believe it is the least smart way to compete with the United States over the long term.

Mr. ANTHONY. You would think the business community would take a look at that.

My family is in business. I guess I will have to pick up the phone and call my father and ask him if he has taken this into consideration.

You have got the youngsters that are in kindergarten now. If they don't get the proper care when they go into the work force—and we do know that in the next 20 years businesses are going to be competing for fewer workers.

There is going to be keen competition for whatever worker is out there.

If that worker is prone to be sick or have greater days off, it seems we are setting ourselves up for a great deal of cost in terms of loss of productivity, absenteeism and even maybe costlier insurance benefit packages because the work force will be sicker.

Therefore, the benefits will have to be greater in order to cover the costs.

Maybe the committee can do some work on it. Maybe the business community, if they are going to come in here and testify, maybe we can hear from them, if they have thought about it, if they have conducted studies.

At some point, we are going to be forced to make this balance.

Before I let go of this bone I started gnawing on a moment ago about taking care of rural America, the chairman showed me a study done for California. It bears out the point that in some of the more rural States the numbers of the people who are uninsured have gone up dramatically.

You mentioned Oklahoma. They are just a spot above Arkansas in terms of how that increase has occurred.

If you look at the Northeast, it drops down dramatically. If you look in the Pacific Northwest, it drops down dramatically.

If you are talking about an uneven economic recovery in this country, you can say there is a growing body of evidence that you have an uneven distribution of quality health delivery system occurring in this country among the states. I think that is something we need to take a look at.

I enjoyed your point about consolidating hospitals. If you consolidate a hospital in a rural area, more than likely you are going to consolidate it about 100 miles away instead of 30 miles away because most consolidation occurs within the county with the exception of the areas where a lot of the population sits on the county line.

We are going to have to talk about some type of regional delivery system and a transportation system.

That is where most of these poor people—they can't even get 45 miles in their own county, much less 120 miles to the best hospital in the country or in the region.

We have a lot of problems there.

Thank you for your testimony.

Mr. LEVIN. Mr. Chairman, as he leaves, might I ask you if you could pick up a copy of the NFIB testimony?

Mr. Rehr will be here later. Give us your thoughts about some of the data in the testimony. There are some differences. For example, in your testimony, it says 32-to 37-million uninsured, 17 million are nonworkers and 3.7 million are seeking employment, which is quite different than your figure that about two thirds are currently holding a job or in families with an adult currently holding a job.

Also, further on the NFIB talks about the number of small business owners providing employee health insurance has been steadily rising. I don't quite know how we put that together with the diminution in the number of people who are covered by health insurance. If you have any thoughts on that?

Mr. BLENDON. One thing I would again mention for the record, in order to make it easy for the committee on the uninsured numbers, I only used numbers from the Congressional Budget Office and the report that you hold from the Congressional Research Service.

All those numbers are in there because I tried to avoid the dispute which often occurs among academics before this committee because a number is slightly different. All those figures are reflected.

I gladly will send that in. Since that staff is available to you, that is what I thought would be the easiest to use.

Chairman STARK. Sir, thank you very much.

We will now hear from the Massachusetts panel. I would like to point out that we were willing to give any other State equal time, but they couldn't make up their minds whether they wanted to have Maine or Texas. We settled on Massachusetts as a middle ground.

We would like to welcome Philip Johnston, the secretary of human services for the Commonwealth; Nancy Mills, executive director of the Service Employees International Union, Local 285, Boston; and Jack Cogswell, the treasurer of the New England Telephone Co. from Boston, MA.

Your prepared testimony will appear in the record in its entirety without objection. In the order which I welcomed you, I hope you will summarize or expand on your testimony or enlighten us in any manner you are comfortable.

Secretary Johnston.

STATEMENT OF PHILIP W. JOHNSTON, SECRETARY OF THE EXECUTIVE OFFICE OF HUMAN SERVICES, COMMONWEALTH OF MASSACHUSETTS

Mr. JOHNSTON. Thank you.

It is a pleasure to be here to join with two of my colleagues from the Commonwealth of Massachusetts who are instrumental in helping to make the coalition which helped pass this legislation. Karen Smith from the executive office helped in the initial implementation of it.

I am pleased to testify this morning on the value of one approach to ensuring health security for all of our citizens, the creation of a public risk pool supported by employee contributions. I believe it is time for the United States to join the countries that guarantee basic health coverage and I hope that Congress will pass such legislation this year.

The Massachusetts Health Security Act that was signed into law on April 21, 1988, by Governor Dukakis represents the work of payers, providers, business and government. Months of very long, difficult negotiations resulted in our law, which is similar to proposed Federal legislation in that it strengthens the link between employment and health insurance and confronts serious inequities in employer-financed health care. The inequities we are trying to correct exist in every other State: Employers who provide health benefits subsidize the uninsured employees of other companies. While other states may have a different delivery payment system, the fundamental problems are the same from state to state.

In my remarks today I would like to focus on the role that Massachusetts businesses and their employees played in preparing the health system and political system to support universal health care. I believe that we benefited from the very high level of awareness and understanding of the technical health financing issues. The Massachusetts Business Roundtable and organized labor have coauthored the last three hospital payment systems in our state. As a result, they have come to appreciate that there is no "free lunch" in health care. When uninsured people show up at hospital emergency rooms, they receive care that the insured employees of the State pay for. We have a free care debt pool in Massachusetts totaling $315 million, a very sizable sum of dollars. That $315 million free care pool is being financed by businesses which provide health care. Most of the corporations that do business in Massachusetts do provide health care to their employees. It is very clear that those corporations are subsidizing the few recalcitrant corporations which just simply as a matter of policy choose not to offer health insurance to their employees. The interesting political phenomenon which occurred in the negotiations around this bill was that the vast majority of people in the business community wanted something done about this fairness issue and the lack of equity from corporation to corporation. To the credit of the roundtable and labor, they did not retreat from their commitment to cover these services once the somewhat staggering financial bill was presented. Quite reasonably, they demanded more accountability and more efficiency.

Business, labor and Government agreed on several points, which gave us a base from which to build the universal health care bill.

First, the private insurance system that serves the majority of working people and their families could not be weakened unless there was an equal or better alternative.

Second, that there are some individuals, such as the very poor and disabled, that are the Government's responsibility.

Third, that the uninsured be brought into the same health system as working people and be subject to the same cost control and efficiency measures.

And fourth, that the insurance system should exert more pressure on providers to control costs and improve quality of care.

These principles and a willingness to address the real, practical problems facing the business community were critical to success. This willingness helped us deal with concerns raised by small businesses, new companies, and industries that rely on part-time workers. The State risk pool that is available to individuals not covered by employer plans or Medicaid should maximize the numbers of insured individuals, thereby minimizing the adverse selection that has plagued small business underwriting.

The final legislation provides for a partnership of business and Government. Most health insurance will be provided by private purchase through the workplace, as it is now. People unable to obtain insurance this way may purchase it from private insurance companies or HMOs through group contracts arranged by the state. For such people there will be a Medical Security Trust Fund which will share the premium cost, as the employer normally would. The trust fund will be financed by a medical security contribution paid by those employers of six or more persons who do not directly pay the required contribution amount for employee health benefits. The annual contribution requirement will be 12 percent of the first $14,000 of wages, that is, no more than $1,680 per employee in 1992 dollars. Employers' actual expenses for employee health benefits will be deducted from this amount to determine the payment to the trust fund. The trust fund may also be supplemented, if necessary, by State appropriation. We certainly hope that won't be necessary, but one never knows in this business.

In addition, there will be several other programs involving public and the private sectors, which we can get into if you have questions.

In conclusion, I would like to reiterate that the public-private partnership we have crafted is an enormous step forward, and one that recognizes the needs and constraints of constituencies that must cooperate to improve the health security of our citizens.

[A more detailed description of the employer contribution follows:]

Employer Requirements Under Chapter 23

Chapter 23 does not mandate any employer or business to offer health insurance to their employees. It will require employers of six or more employees to contribute to the cost of health insurance for the uninsured.

- Beginning in 1990, there will be a .12% unemployment health insurance contribution on the first $14,000 of an employee's wage ($16.80 per worker). This will be assessed on all employers who have six or more six employees to help finance the cost of insurance for the unemployed uninsured who are receiving unemployment compensation.

- In 1992 there will be a 12% medical security contribution on the first $14,000 of an employee's wage ($1,680 per worker) assessed on all employers with six or more employees to help finance the cost of insurance for the employed uninsured. However, employers who provide health benefits will be allowed to deduct this cost from the annual $1,680 surcharge.

To determine the estimated medical security contribution amount, if any, that an employer may be subject to, take the total amount spent for employee health benefits, inflate this amount by 9% per year to 1992 (estimated health benefit inflation rate) and then divide it by the number of employees in the firm (excluding the three types of employees listed below). If the number is greater than or equal to $1,680, the employer will not incur any additional liability in 1992. If the number is less, then the employer will be surcharged for the difference between what is spent per employee and $1,650.

Employers will not pay a surcharge for the following classes of employees:

- temporary or seasonal employees (who work 5 months or less)
- part-time employees who work less than 20 hours a week
- employees who already have health insurance coverage (for instance, when one worker is covered by the spouse's plan)

Special provisions are included for new employers so that the surcharge is only gradually applied. For small business, a health insurance hardship trust fund will be established to provide assistance to employers that are severely impacted by the medical security contribution. In addition, there are tax incentives for small businesses to begin to offer insurance.

One of the primary goals of this legislation is to more equitably distribute the cost of providing health care to those presently uninsured. Prior to enactment of this law, businesses which offered health insurance were paying twice - once for their employees, and then again by paying a 13% tax to hospitals to finance uncompensated care generated primarily by employees of businesses which do not offer health insurance. As universal health coverage is phased in over the next several years, there will be less money needed to finance uncompensated care and businesses that provide health benefits will no longer have to pay for those without insurance.

Health Security for All

Approximately 600,000 (10%) Massachusetts residents do not have health insurance. Two thirds of the uninsured are employed adults and their dependents. Currently access to health care for for those who cannot afford hospital care is provided through an uncompensated care pool. The legislation creates many new programs to make health insurance available to the uninsured by mid 1992, according to the following schedule.

- Disabled adults who are employed and disabled children of working parents will have primary and supplemental health insurance which will cover needed services for the particular medical condition available to them on July 1, 1988 through the Department of Public Welfare.

- On July 1, 1988, the Department of Public Welfare will be expanding Medicaid eligibility to two new groups whose incomes are less than 185% of the federal poverty standards; pregnant women and infants, and women returning to work if their employer does not offer health insurance.

- The new Department of Medical Security (DMS) will begin several programs to assist small businesses so that they will offer health insurance in 1989. These programs include a new small business group insurance purchasing pool and technical assistance grants to private brokers of health insurance.

- DMS will begin two demonstration initiatives in 1989 that will offer several different health insurance plans to limited numbers of the uninsured.
- On September 1, 1989, all college and university students studying at least three-quarter time will be required to have insurance.
- In 1990, a two-year tax credit will begin for businesses with 50 or fewer employees that have not offered health insurance before as an incentive to begin offering health insurance to their employees.
- In 1990, the unemployed and their dependents who receive unemployment compensation will have available health insurance through the Department of Medical Security.
- In 1991, the Commonwealth will provide for the acute hospital care of General Relief clients that was previously funded by the uncompensated care pool.
- In 1992, employers of six or more employees will be assessed a medical security contribution of not more than $1,680 per employee. Employers will be able to deduct from this amount their costs for health benefits.
- In 1992, the Department of Medical Security will establish a Health Insurance Hardhship Trust Fund to assist small businesses whose medical security contribution exceeds 5% of their gross revenues.
- In 1992, the Department of Medical Security will make available to all remaining uninsured a variety of health insurance plans.

Chairman STARK. Thank you very much.
Ms. Mills.

STATEMENT OF NANCY MILLS, EXECUTIVE BOARD MEMBER, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, AND DIRECTOR, LOCAL 285, BOSTON, MA

Ms. MILLS. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Nancy Mills, director of Service Employees Local 285 located in Boston, Mass., but representing about 9,000 workers throughout the State of Massachusetts. On behalf of my members in Massachusetts and all of SEIU's members in the service sector, I welcome this opportunity to comment on the erosion of employment-based health care and the steps needed to reverse that trend, and specifically on the health security act passed in Massachusetts this year.

SEIU Local 285 is confronted every day by the rapidly growing problem of uninsured workers. Our 9,000 members work in hospitals, nursing homes, health clinics, and in local and state government agencies.

Like our sister locals organizing in the building service and clerical industries, our membership includes the lowest paid tier of the work force, those people who have the least likelihood of benefits.

Our jurisdiction has expanded greatly in the last decade, as the service industries boom swept our State, but the economic conditions for workers have stagnated or actually worsened.

In no area is this more true than in health care benefits. The high costs of care meant that service employers who previously provided health insurance reduced benefits in several ways: by making the cost to workers prohibitively expensive through high premium contributions, increased deductibles and copays; by excluding large percentages of workers who work part time, the fastest growing area of the work force in many service industries; and by restricting employer payment for coverage to the worker alone and not the children or spouse, a cost-saving device which, for many low-wage workers, effectively eliminates family coverage.

For those employers without a tradition of providing coverage prior to the health cost explosion of the early 1980's, health care inflation became an incentive to structure the work force to avoid coverage by, for instance, relying mostly on part-time workers, or by simply refusing to provide coverage because of cost.

Massachusetts is not as bad as some because our economy has been quite successful of late, but we still have some 450,000 workers and their dependents without health coverage by recent count.

And try as we might, unions have not been successful in solving the crisis of eroding coverage through collective-bargaining activities.

My union is one of the most aggressive, and modestly most successful, at organizing low-wage workers, but frankly, for the past few years we have had all we can do to just hold on to the health coverage we negotiated 10 or 15 years ago, never mind expanding that coverage.

We have also tried our best to address the erosion of coverage through cost containment efforts. With the help of SEIU, my local has made cost containment a standard proposal in contract negotiations, as an alternative to cutting back coverage.

Clearly, the situation in Massachusetts was not about to improve without a major policy shift which had the backing of consumers, providers and purchasers and that is what Governor Dukakis engineered in the universal health care bill.

I want to talk about the specifics of what was going on in Massachusetts from our perspective, from organized labor, that led to this.

Secretary Johnston already mentioned what we have incorrectly called the free care pool in Massachusetts. First of all, it certainly wasn't free. It was quite, quite expensive. This was a system of a surcharge on hospital charges.

In fact, when the free care pool was originally created, was established through legislation, the amount of that surcharge was approximately 7 percent, a 7-percent charge on hospital charges. When we sat down to write the new Health Security Act, the amount of that surcharge was up to almost 13 percent.

There are lots of reasons why that may have grown. One of them, I believe, was that employers were responding to the fact that their employees would be getting this so-called free care if they walked into the emergency rooms of hospitals; even if there wasn't a public hospital in their area, they could walk into a private, voluntary hospital. That hospital would know that it would get compensated for that care on the basis of this surcharge.

A number of irresponsible employers I believe responded to that fact by cutting back on coverage for their employees. It was because of that, the fact that it was expensive, the fact it was often inappropriate care, as someone mentioned earlier, when you walk into an emergency room, that is first of all usually too late for the care that would have created a healthy individual, but certainly the most expensive care you can get. It was a response to that that the business community, in particular, and I want to give credit where credit is due, a large part of the momentum for this bill did come from the business community both out of its self-interest in making sure that it wasn't picking up the cost for those employers who were not being responsible and not insuring their employees, but also from an understanding that the long-term health of their employees and their children would be in their long-term interest.

The other problem was there was tremendous public subsidy in the form of surcharge, in the form of hospital bills that went into the fact that a large amount of the free care provided in Massachusetts, again incorrectly called free care, the care being provided in Massachusetts to those 6,000 working people and their families was being done in public institutions in the Boston city hospitals of the world, and that care was indeed again not free, that it was being compensated by the surcharge and also by other forms of public subsidy and tax money.

That was the situation that we found ourselves in when we entered the negotiations for the Health Security Act: One, that care was increasingly being provided to those people uninsured by increasingly expensive surcharge, and also by the fact that it was quite clear that the trend with more employers not providing insurance was a growing trend.

There was another reason other than providing access to people currently without health coverage, that the Massachusetts legislation was necessary: The Massachusetts health delivery system, which by anyone's standards would rank among the finest in the Nation, has been racked by years of intense competition and Government experimentation with ways to control costs. By 1987, the acute hospital field in Massachusetts was badly in need of stabilization.

On behalf of the Massachusetts State Federation of Labor, and its president, Arthur Osborne, I participated in the Governor's Study Commission on Health Care Finance and Deliver Reform and in the various discussions and negotiations on the legislation which eventually was signed into law.

At the same time as I applaud the initiative and the bill as it was enacted, I want to point out that much more needs to be done to finally resolve the problems of access to care and health care financing. And part of what we learned in the process of passing this legislation was that this really needs to be addressed on the Federal level.

Because nearly three quarters of the 37 million insured Americans are workers and their families, requiring employers to provide basic health coverage is the critical first step towards solving the current health coverage crisis. Some of SEIU's own low-wage members, who are janitors, clericals, nurse and home health aides, would receive health benefits for the first time. Other SEIU members would see lower health costs, as responsible employers no longer have to pick up the tab for businesses that fail to offer health coverage to their workers.

Because more and more employers are failing to provide basic health insurance for their workers, this approach is in a long and uniquely American tradition of setting minimum standards for private enterprise when they don't do so themselves.

In this regard, it is no different than other minimum standards for employers provided by statutes—the 40-hour work week, unemployment insurance, the minimum wage and social security.

I have provided a lengthy testimony which I will not go into any further. I want to comment on a couple of things about the bill we were able to achieve in Massachusetts that were both, I believe, models for national coverage, but also some areas of compromise which, although the labor movement in Massachusetts enthusiastically endorses the outcome of the bill or wants you to look at with a finer eye when you craft your own legislation.

One is without question the fact that this is employer based, is a very important part of the labor movement's support for the legislation.

Second, the fact that the legislation was one that specifically addressed relief for low-wage workers, workers near the poverty line, and recognition there needed to be specific and special consideration for their ability to meet any deductibles was an important part of the legislation as well.

Third, the fact that there was specific incentives in the bill to encourage disabled workers or workers with prior existing conditions to be able to reenter the work force and have insurance.

One of the main reasons those individuals had not reentered the work force was because they couldn't get health—it was smarter for them to stay out of the work force. The fact this legislation addressed that problem was an important part of the labor movement support for the legislation.

There are two specific areas that I would caution you about. Although I am aware of the kind of concerns that Dr. Blendon mentioned about putting too high a price tag on any mandated benefit package, the Massachusetts legislation has no actual mandated benefits per se.

Now, that was a big problem for organized labor, and will continue to be something we will look at with some degree of carefulness and concern.

Instead, the Massachusetts legislation simply mandates a certain dollar contribution towards health insurance. The fact of the matter is, this may not be a big problem in Massachusetts given a whole other range of mandates that do exist as well as an administration and government that will, I believe, look very carefully to make sure that the dollars are being spent to provide health care coverage.

Nevertheless, it is something that we are concerned about. Dollars spent on health care which don't translate into specific mandated benefits may be a problem in the future.

Chairman STARK. If I could interrupt, would that have gone away if it were not for the ERISA problems? Was that an intention among the groups negotiating this?

The fact that you don't have benefits specified, was that strictly to take care of ERISA?

Ms. MILLS. No, it was not to take care of the ERISA problem.

The other area of concern that the labor movement has was the fact that our part-time definition was 20 hours a week, higher than the labor movement in fact was happy with. We have seen, not only in our own industry but in many industries in Massachusetts, a trend and tendency to be hiring less than 20-hour-a-week workers, workers who are not able to find health insurance through that employer or others.

That is a big concern of ours and one that we would not support enthusiastically on a federal level if that were the number. I think in Massachusetts, because of the employment situation being as good as it is, it was not such a big problem.

I want to say that there is just one other alarming trend that I want to draw the committee's attention to, that I mentioned sort of briefly. In addition to the concern about the breakdown of workplace health coverage completely, meaning the removal of health care coverage for working Americans, employer after employer are coming to the table with high deductibles and copays. So even though health insurance may technically exist, the amount of those premiums, deductibles and copays may effectively mean the employees cannot afford it.

So in addition to making sure the bottom line insurance coverage is there, we have to make sure it is not just there on paper but there in reality, because the employees cannot afford to pay the costs.

I want to close by saying our support for the Dukakis legislation in Massachusetts is a microcosm. We will pledge to do whatever we can on a local and national level to make sure that the first question asked of a sick person who enters an emergency room of a hospital, whether it be in Massachusetts, Arkansas, or Michigan, is "Where does it hurt?" and not "How are you going to pay for it?"

Chairman **Stark**. Thank you very much.

[The statement of Ms. Mills follows:]

Testimony of
Nancy Mills
On Behalf of
Service Employees International Union, AFL-CIO, CLC

Improving Access to Health Care

I am Nancy Mills, Director of Service Employees Local 285 in Boston, Massachusetts, and an Executive Board member of the Service Employees International Union. On behalf of my members in Massachusetts, and all of SEIU's 850,000 members in the service sector, I welcome the opportunity to comment on the erosion of employment based health coverage and the steps needed to reverse this trend.

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Like our sister locals organizing in the building service and clerical industries, our membership includes the lowest paid tier of the workforce, those people who have the least likelihood of benefits.

Our jurisdiction has expanded greatly in the last decade, as the service industries boom swept our state, but the economic conditions for workers have stagnated or actually worsened.

In no area is this more true than in health benefits. The high cost of care meant that service employers who previously provided health insurance reduced benefits in several ways: by making the cost to workers prohibitively expensive through high premium contributions, increased deductibles and co-pays; by excluding large percentages of workers who work part-time, the fastest growing area of the workforce in many service industries; and by restricting employer payment for coverage to the worker alone and not the children or spouse, a cost-saving device which, for many low-wage workers, effectively eliminates family coverage.

For those employers without a tradition of providing coverage prior to the health cost explosion of the early eighties, health care inflation became an incentive to structure the workforce to avoid coverage by, for instance, relying mostly on part-time workers, or by simply refusing to provide coverage because of cost.

My state is not as bad as some because our economy has been quite successful of late, but we still have some 450,000 workers and their dependents without health coverage by recent count.

And try as we might, unions have not been successful in solving the crisis of eroding coverage through collective bargaining activities.

My union is one of the most aggressive, and most successful, at organizing low-wage workers, but frankly, for the past few years we've had all we can do to just hold on to the health coverage we negotiated ten or fifteen years ago, never mind expand that coverage.

The anti-union policies of the National Labor Relations Board make it a monumental task to organize private sector workers. And these same employers who claim they can't afford health coverage always seem to have unlimited funds to spend on attorneys and consultants to fight unionization.

We've also tried our best to address the erosion of coverage through cost containment efforts. With the help of SEIU, my local has made cost containment a standard proposal in contract negotiations, as an alternative to cutting back coverage.

Clearly, the situation in Massachusetts was not about to improve without a major policy shift which had the backing of consumers, providers and purchasers and that's what Governor Dukakis engineered in the Universal Health Care bill.

But there's another reason, other than providing access to people currently without health coverage, that the Massachusetts legislation was necessary: the Massachusetts health delivery system, which by anyone's standards would rank among the finest in the nation, has been racked by years of intense competition and government experimentation with ways to control costs. By 1987 the acute hospital field in Massachusetts was badly in need of stabilization.

On behalf of the Massachusetts State Federation of Labor, and its President, Arthur Osborne, I participated in the Governor's Study Commission on Health Care Finance and Delivery Reform and in the various discussions and negotiations on the legislation which eventually was signed into law.

At the same time as I applaud the initiative and the bill as it was enacted, I want to point out that much more needs to be done to finally resolve the problems of access to care and health care financing. And part of what we learned in the process of passing this legislation was that this really needs to be addressed at a Federal level.

Because nearly three-quarters of the 37 million insured Americans are workers and their families, requiring employers to provide basic health coverage is the critical first step towards solving the current health coverage "crisis". Some of SEIU's own low-wage members -- janitors, clericals, nurse and home health aides -- would receive health benefits for the first time. Other SEIU members would see lower health costs -- as responsible employers no longer have to pick-up the tab for businesses that fail to offer health coverage to their workers.

Because more and more employers are failing to provide basic health insurance for their workers, this approach is in a long and uniquely American tradition of setting minimum standards for private enterprise when they don't do so themselves.

In this regard, it is no different than other minimum standards for employers provided by statutes -- the 40 hour work week, unemployment insurance, the minimum wage and social security.

Together with other public program reforms designed to complement mandatory, employment-based health coverage, we have the opportunity to substantially broaden access to health care in the United States over the next several years.

The rest of my testimony will focus on: (1) the current U.S. health coverage "crisis"; (2) the barriers to health care faced by low-wage employees; (3) the results of a new SEIU study that documents the enormous taxpayer subsidies paid to businesses who do not provide health coverage to their workforce; and (4) SEIU's recommendations for public-private solutions to improving access to health care.

U.S. Health Coverage Crisis

In the United States, unions have long advocated a social insurance system to replace a wasteful and expensive patchwork of privately organized and financed health services. Despite failing to achieve this goal, unions worked to expand private health coverage for Americans through the collective bargaining process.

But medical care inflation -- running at 2 to 3 times the overall inflation rate -- is destroying even this second-best approach. Decades of steady progress, which had extended health coverage to almost 90 percent of all Americans by the late seventies, ground to a halt in the eighties. And the percentage of the U.S. population without health insurance grew by more than 25 percent, to nearly 40 million people.

Cutbacks in public insurance are partly to blame. Medicaid, the program designed to meet the health needs of the poor, now covers 38 percent of people living below the federal poverty line -- compared to 65 percent in 1976.

But the biggest threat to universal health care is the breakdown of health coverage at the workplace. Today, seventy-five percent of uninsured Americans are workers or their dependents. More than two-thirds live in families of full-time, full-year workers.

The decline in employer-provided insurance stems partly from major structural changes in the U.S. economy. With virtually all new jobs coming in the service sector, the shift in the proportion of jobs without health coverage was dramatic. The new service economy spurred the growth of part-time and temporary workers and independent contractors, leaving millions more workers with inadequate protection or no health insurance at all.

These jobs have tended to be low wage, which compounds the problem of access to health care. Three-quarters of all uninsured workers earn less than $10,000 and 93% earn less than $20,000 a year.

In addition to a drastic reduction in the availability of coverage, spiralling health costs spawned a number of public and private cost-containment initiatives in the 1980's. Employers opted to curb their medical inflation, mainly through "cost-sharing" -- forcing workers to pick up a large share of their medical bills.

The result was yet more loss of health coverage. Many companies cut the number of people covered, others failed to provide any insurance at all, and more cut back on the coverage they did offer. In the service industries, our members with health insurance faced sharp hikes in the premiums for family coverage, co-pays and deductibles. This cost-sharing prices health insurance out of reach for many low wage workers and forces many to postpone necessary medical treatment.

The decline in family coverage is especially troubling. In a health access survey of low wage members -- nursing home workers, janitors, food service workers and clericals -- conducted by SEIU last year in 12 states, fully half of the insured workers with children could not afford the exorbitant price of family coverage -- which averaged 30% of take-home pay for the plans sampled.

The survey results parallel a national trend that threatens to shortchange the health of our children. One-fifth of all uninsured children now live with a parent who has employer-sponsored coverage.

But winning new health coverage for low wage workers in the 1980's has been our most difficult challenge. More and more employers have decided that health care won't be part of the employment picture. At this time, SEIU believes that publicly mandated access to health services is the only viable avenue for winning widespread health coverage for low-wage workers, whether they be in healthcare, building service, clerical, public sector, or other industries.

And lest you think this is a problem of only small employers, recent research shows that 40% of the uninsured workers in the U.S. are employed in companies with 100 or more employees. A quarter of them work in firms with over 500 employees.

Low-Wage Workers Face Strong Barriers to Health Care

The failure of employers to provide health insurance endangers the health of millions of workers and their families. In SEIU's health access survey of low-wage workers, over 42% of the uninsured workers said they could not afford to seek medical assistance or have been turned away.

These statistics parallel the findings of much larger studies which others have done, notably the Robert Wood Johnson Foundation. Their 1986 survey found strong obstacles to health care among the U. S. population. According to the survey, 43 million people (18 percent of all Americans) reported no regular source of care -- a 65 percent jump since 1982. In 1986, more than 16 percent of all Americans -- nearly 40 million people -- needed medical care but had difficulty getting it. Another 15 million people did not seek care because they could not pay for it or were denied care. Among uninsured Americans, all health indicators have worsened since 1982, while the general health of the population has improved.

Public Subsidies to Employers Who Provide No Health Coverage

The sicker uninsured population has high medical bills. Who pays for their care? The 24 million uninsured working Americans and their families often end up at the door steps of our public hospitals and emergency rooms -- requiring public subsidies from a variety of sources. Some of it comes from federal dollars, some from state dollars, some from local dollars. But it all comes from taxpayer dollars.

The working poor in some states can apply for public health insurance -- federally-assisted Medicaid funds or state-financed "medical relief". But few have this safety net.

Local governments shoulder substantial burdens for the growing population without health insurance. Most workers without employment-based health coverage rely on subsidized public health services for the poor -- through public hospitals, county clinics and health department programs. While public hospitals account for only one-quarter of all hospital care, they provide more than 40% of all charity care. Local governments also make operating grants to non-profit facilities to help defray the cost of care for the poor.

The size of these public health subsidies is enormous. Nationwide, hospitals' total uncompensated care (charity care and bad debt) reached nearly $8 billion in 1986, more than double the 1982 rate. States spent more than $2.3 billion on medical relief programs and cities and counties contributed $12 billion in non-capital support to public hospitals in 1984. Adding up other public subsidies -- e.g., tax-exempt bond financing and support to non-profit hospitals -- would raise the total taxpayer burden considerably.

Employers who fail to provide health coverage to their employees reap enormous taxpayer subsidies.

To illustrate how taxpayers subsidize low-wage employers, SEIU recently surveyed over 1,000 home care workers employed by the Los Angeles County. They earn only $3.72 an hour and have no health insurance.

Over 60 percent of the mostly female and minority workers have no health insurance coverage from any source. The 40 percent who do, have it by virtue of their spouse, or because they're so impoverished they qualify for public assistance.

About seven percent of these workers get health insurance through direct public insurance, in this case the Medi-Cal or Medicare systems.

But it also revealed that many more enter the public health system through the back door. Over 63 percent of the home care workers with no health coverage use publicly funded emergency rooms and community clinics as their primary source of health care. Nearly 54 percent use the emergency room or county hospitals. Another 9 percent customarily use community clinics.

The difference in the pattern of medical care between insured and uninsured LA County home care workers is striking. Those with private insurance overwhelmingly (64%) use private physicians as their primary source of care.

We estimated the total group of 40,000 workers requires some $21.4 million each year in public subsidies for health care.

The study also says that because of low wages, the workers have to depend on various programs of low-income assistance (AFDC, food stamps, WIC, SSI etc.) to meet basic needs, totalling another $38.6 million yearly.

These taxpayer subsidies are quite high, when sized up against a payroll totalling $176 million in 1988. Current legislation in Congress to require workplace health coverage would save taxpayers $15.1 million this year, an amount that rises to over $28 million by 1992, for this single employer.

Over half the savings by 1992 would accrue to public insurance programs -- $10.9 million to Medi-Cal and $5 million to Medicare. Los Angeles County hospitals and clinics would save $12.5 million in indigent care costs by 1992. And if this were a private sector employer, the taxpayers would save a net of $28 million per year.

This study illustrates another point. Improving access to health care would not add significant new health expenditures. Instead, most health costs are already in the system and would simply be transferred from one group to another. Significant public/private savings in uncompensated hospital care, tax levies and general medical assistance moneys would be expected.

Improving access to health care would have other societal benefits, not the least of which are the broader health benefits and cost savings that come from reduced illnesses and premature births because of the improved access to early medical treatment that health insurance buys. And adequate health insurance also steers patients away from the inefficiency built into the back door financing of indigent care through hospitals, undeniably the most expensive health care setting.

Approaches to Improving Access to Health Care

We believe a consensus now exists across a broad political spectrum that substantial reform is needed to broaden health coverage for the 37 million uninsured Americans under age 65. At the same time, the consensus does not extend to what should be done.

We and other members of the labor movement remain convinced that the only way to assure that all Americans have access to affordable, quality care is through the enactment of a national health care program.

However, SEIU has come to the conclusion that a package of intermediate reforms, building on our pluralistic system, can basically accomplish our goal of universal health coverage. A carefully crafted package of reforms that meshes together the best of our public-private health systems would include:

- Requiring that most employers provide basic health insurance packages to their employees and dependents through minimum standards (Kennedy-Waxman Minimum Health Benefits for All Workers Act of 1987) or else face equivalent tax surcharges.

- Medicaid reform to decouple low-income health coverage from AFDC, create uniform eligibility standards at 100% plus of the poverty line for all states, improve provider participation and make Medicaid flexible enough to combine with private, employment based insurance.

- Coverage for the permanently disabled, jobless and others without work attachment through privately-funded state insurance pools and public programs.

- A new financing mechanism for long-term care that removes nursing home payments from the Medicaid program.

Most of these approaches could be treated as alternatives. For example, public programs could cover everyone under 100% of poverty, but at high cost to the Treasury. Preliminary estimates of the cost to extend Medicaid eligibility to persons with income below the poverty line, in conjunction with the uncoupling provisions, range from $15 billion to $30 billion in federal and state monies. In part, these costs stem form the fact that some of the working poor and near-poor have private health insurance coverage through employers. Without a mandate or strong tax incentives, public coverage would displace current private coverage and add considerably to public outlays. While some of these costs could be defrayed through a "buy-in" approach, low-income workers would require substantial public subsidies. Given the huge federal budget deficits, public funds might be better targeted on those low-income uninsured falling outside the workforce.

Taxing hospitals or private health insurance plans to cover uncompensated care costs would add more money to pay for indigent care, but it also shifts the financial burden of covering the uninsured onto the insured. So this approach preserves the inequities in the system, whereby employers providing coverage for their workers pick up the tab for firms not providing coverage. In addition, it would continue the cost inefficiency of treating the uninsured through hospitals and other expensive settings.

A bill to require most employers to provide health coverage to the workers has enormous advantages. Most importantly, it would provide health protection to two-thirds of all uninsured workers. It would also build on the current system of employer-provided private group health insurance and spread the cost of expanded coverage more equitably among firms. Employers who provide health coverage would no longer subsidize employers who fail to provide health coverage. And it conserves scarce public health dollars that now go to subsidize those employers who do not provide health coverage.

SEIU strongly supports the basic health standard approach taken by the Kennedy/Waxman bill. This legislation requires all employers to provide a minimum level of health insurance for employees who work at least 17.5 hours or more weekly. It is in the American tradition of other minimum standards -- like the minimum wage, unemployment insurance and social security.

Modelled as a minimum standard, the bill can not provide cadillac benefits. But it does cover necessary hospital care, doctors' bills, diagnostic tests, pre-natal and well-baby care. All plans must provide catastrophic health protection through a $3,000 limit on out-of-pocket expenses. And the bill places a maximum 20 percent limit on coinsurance for most services.

Several features of the bill are especially important to low-wage workers:

- ■ Relief for low-wage workers, defined as those earning less than 125 percent of the minimum wage, whose employers must pick up the full cost. About half of all uninsured workers would benefit from fully-covered premiums. Other employees would pay a maximum 20 percent of the premium cost.

- Broad coverage of part-time employees working 17.5 hours a week or more. This threshold covers 77 percent of part-time workers with no health coverage; limits the economic incentives to displace full-time workers; and follows the federal definition of part-time work for other benefits.

- Fully paid prenatal and well-baby services - Clinical prevention studies have demonstrated the cost-effectiveness of such services in reducing the incidence of premature births and low-weight babies.

It's also becoming clearer that the harder you push the mandatory, employer-based approach, the more Medicaid reform becomes inescapable. Employees working for very small firms, some part-timers, and temporaries and part-year workers and the like may not get coverage as the political process works out.

Moreover, many low-wage workers can't afford high deductibles and co-pays, especially for family coverage. The SEIU survey of its low-wage members across the country conducted last summer showed that deductibles in the $500 range for family coverage are a barrier to coverage for children and to low-wage workers seeking out medical care.

In previous testimony, we have suggested possible ways to rearrange a minimum benefit package to lower deductibles, while keeping average contribution rates the same. Medicaid could also serve as "wrap-around" insurance to pick up out-of-pocket expenses (co-pays and deductibles) for low-income working Americans, enabling them to fully participate in private insurance.

The House-passed welfare reform bill includes a Medicaid "wrap around" provision for the newly-employed who go from the welfare rolls to jobs that provide some health coverage.

Medicaid reform to eliminate categorical eligibility, to set eligibility at 100% of poverty and to encourage provider participation and reimbursement reform to improve access would be necessary, perhaps in concert with risk insurance pools, to close the remaining gaps for non-workers and the disabled. We would also suggest covering nursing home payments under a new financing system to alleviate the heavy financial burdens placed on Medicaid, the public payor by default.

The elements of this reform package are highly integrated. For instance, the mandates are necessary to maintain the core of employer-based coverage and to make the government a secondary payor, keeping the public costs at a more manageable level.

Taken as a whole, these recommendations could provide health protection to nearly all 37 million uninsured Americans. At the same time, careful attention to the meshing together of the private-public healthcare systems for low-wage workers and smaller employers will establish a more efficient and cost-effective system of health protection than either would alone.

Conclusion

In short, a package of health reforms to improve access to health coverage must guide our policy direction over the next legislative term. At the heart of this reform package is a minimum standard providing for basic health care at the workplace, as a cost of doing business. Such a bill will reap enormous benefits -- coverage for 23 million workers and their families, better health care, protection against financial hardship and enormous savings in taxpayer subsidies to businesses that won't voluntarily provide health coverage. The proposed Medicaid and long-term care reforms are complementary to this private employer-based coverage and taken as a "package", they would significantly expand health care for all Americans.

Chairman STARK. Mr. Cogswell.

STATEMENT OF JOHN COGSWELL, SECRETARY/TREASURER, NEW ENGLAND TELEPHONE CO., REPRESENTING THE MASSACHUSETTS BUSINESS ROUNDTABLE

Mr. COGSWELL. Thank you.

I am appearing today as a representative of the Massachusetts Business Roundtable, which is an organization comprised of senior executives. The roundtable has been an active participant in the Massachusetts health care policy debate for most of the past decade.

Like business representatives throughout the United States, we are concerned about the alarming rate of increase in health care costs and its impact on the overall economy of our country. At the same time we recognize the importance of protecting access to health care for all citizens, including the millions of uninsured, both employed and unemployed, throughout the United States.

The objective in Massachusetts has been to establish a system which provides for more equitable financing and more efficient delivery of care for those without insurance.

It is too early to know whether or not the Commonwealth's recently enacted universal health care law will be successful in achieving these goals. However, we have begun a political process aimed at achieving progress and consensus, a process which involves business, government, labor, insurers and health care providers.

Before passage of this legislation, care for the uninsured in our State was financed primarily through a statewide hospital surcharge system. One problem was that this system forced employers offering insurance to indirectly subsidize those not offering coverage. A second and even more serious problem was the growth rate in the surcharge, as Nancy mentioned, and the resulting uncompensated care pool which by 1987 was requiring funding in excess of $300 million.

In theory the new system should be an improvement. The private sector contributions to the pool are capped at their present level and are to be reduced by about 15 percent over the next few years. The legislation requires most employers to contribute and emphasizes managed care with the objective to have quality care provided to the real uninsured in as cost effective a manner as possible.

The success of this new system will depend on a number of factors, including the design of the State-sponsored health plan and the manner in which it is administered.

One major concern remains the potential underfinancing of the trust funds which have been established to finance this care for the uninsured. Such underfunding could result from a combination of circumstances: an overly generous benefit package, an ineffective small business incentive program, or an inadequate surcharge level.

Whatever the cause, a revenue shortfall would force the state to either scale back benefits, alter eligibility criteria or, more likely, to look for alternative sources of additional revenue—thus our principal concern.

We are also concerned about the growing number of mandated benefits which have become part of the general movement to ensure access. While we recognize the need to establish a minimum benefit plan, an inflated insurance package will only encourage business opposition, attempts to avoid the major cost impacts, and increase the risk of underfinancing.

In light of these concerns and other potential administrative management and implementation problems, in the Massachusetts case we strongly supported a phase-in approach toward achieving the prime objective. Such a transition will allow business, government and other participants to carefully assess the new programs in light of developments and information developed and to make adjustments in the entire program as necessary.

Sweeping social legislation such as the new Massachusetts law will certainly affect the economy and business climate in our State. Unfortunately it is not possible to accurately assess the impact of this legislation until new health insurance programs have been implemented and more data are developed.

During this transition period of the next 4 years, we plan to monitor carefully the bill's impact in areas such as: cost increases for the private sector, especially among small businesses with a lower than average wage base; the effect on the economic health of Massachusetts, particularly concerning inflation, our competitive position and impact on the creation of new jobs; the size of the employer surcharge; the establishment of a competitive insurance marketplace in Massachusetts; the effectiveness of small business incentive programs; and, most importantly, the effectiveness of the program in containing overall system costs.

As you can see, passage of the Massachusetts law marks only the first step in what must now become an ongoing effort to more effectively manage care and ensure access in as cost effective a manner as possible.

Making this law work is no simple task. Fortunately we are encouraged by the cooperative efforts thus far of business, government and labor, all of whom have recognized the importance of health care cost containment and have stepped up to their part of the bargain.

We hope our experience in Massachusetts over the next few years will prove useful to those of you who have the important responsibility of shaping our national health care policy.

Thank you very much.

Chairman STARK. Thank you.

The questions I am going to ask the panel I am sure you have already debated the pros and cons to, but I wonder if I could get under the standard litany and find out what the political pressures were. For example, do you exempt basically businesses with fewer than six employees?

Mr. JOHNSTON. Fewer than six.

Chairman STARK. It seems to me that leaves a lot of people out of the picture.

Was that just pure politics on the small business person? Did the unions back off because they don't organize those businesses?

Mr. JOHNSTON. There was a sense, Mr. Chairman, that the small businesses should have some added break here, and they get it. Those employees will be covered still through the uncompensated care pool, which will remain in effect but substantially reduced in size.

Chairman STARK. Explain that to me.

Mr. JOHNSTON. There will still be an uncompensated care pool for those persons who are either not working—about one-third of the 600,000 uninsured in the Commonwealth are not employed, or 200,000—or those workers who fall into categories which are exempted from the legislation.

Chairman STARK. So if I am working at a service station with only four employees, I would have free coverage?

Mr. JOHNSTON. Through a sliding fee, you will be able to receive coverage.

Chairman STARK. And I pay it?

Mr. JOHNSTON. That is correct.

Chairman STARK. And my employer pays nothing?

Mr. JOHNSTON. That is right.

Chairman STARK. If the guy across the street has 10 employees, he has to contribute something, and my employer, who keeps under 6, doesn't pay anything.

Do both employees pay the same amount? Does an employee in a larger business pay anything out of his or her pocket?

Mr. JOHNSTON. Whatever the employer requires.

Chairman STARK. So it is conceivable—again a Shell station on one side and a Texaco station on the other side—that the employees may be hit with different costs.

Mr. JOHNSTON. Yes.

Chairman STARK. Was that a contentious issue? Were you trying to get it down to two employees?

Mr. JOHNSTON. It was very contentious.

Obviously the real concern when this bill hit the legislature was the universal health care issue. There were two pieces: hospital care and universal health care. The hospital payment system was resolved separately.

The feelings of the small business community were paramount in the legislature during the process. There were a number of incentives which were provided to the small business which were contained in the bill. It was a tax incentive, hardship for businesses having five employees or less, and a number of others. There were some pooling arrangements offered to the small business community, et cetera.

I think it was through a lot of effort and work on the part of people in the legislature, people in the small business community, that we finally came up with a package which the small business community could live with.

I say that very broadly because there are some representatives of small businesses which continue to resist the idea. But it was critical to enactment of the bill.

Chairman STARK. Would you advise if there was even the remotest possibility of going down the line? I suspect we are going to have to subsidize the smaller providers with the smaller number of employees. I suppose there are some costs, while there are some cost savings in the larger group plans.

Do you think it might be politically easier to just provide it and find a way to pay for it out of a much broader based revenue source than trying to make these adjustments and negotiate?

I think what you are telling me is that the small business group will not support it, regardless of what you do.

Mr. JOHNSTON. No.

I am sure Nancy and Jack will want to comment on this.

I think the driving principle behind the Massachusetts legislation is that we believe this should be a partnership and therefore all parties must buy into this problem in one way or another, buy into the solution of the problem in one fashion or another.

That means in a political sense it is a much more difficult kind of problem to resolve, I suppose, than it would be to simply propose a broad-based tax to finance health care for the uninsured.

The negotiations around this legislation went on and on and on and on, and I have the scars on my back I can show you, and the Governor does as well, and the leaders in the legislature do.

I think it was worth it in the end. We have a true partnership. There is not any sector in our state which is exempt from playing an important role. There are many small businesses which are hardly starving. There are many profitable small businesses. The fact that one is running a small business does not mean they cannot or should not provide health insurance to their employees.

Chairman STARK. Did they just withhold it to be mean?

Mr. JOHNSTON. I think there are economic decisions made by proprietors of corporations or CEO's of corporations, whether they are large or small, and they are largely driven by bottom line considerations. I think everybody understands that.

The fascinating thing we found in Massachusetts was that it was not really the small business person who was not providing—as a general statement—health insurance. Many of these are national chains which are making big, big bucks and were not, as a matter of policy, providing health insurance to their employees.

There are lots of ways they can do that—by relying on part-time workers, as the president of the United Auto Workers indicated is the case in many States. It is certainly true in Massachusetts.

So I don't want to leave the committee with the impression that this is largely a small business issue. We find the small business people generally were very concerned about their employees and wanted some help to provide health insurance to their employees.

I think the larger problem politically is dealing with these larger operations which just simply have been recalcitrant.

Chairman STARK. Did you exempt employees who were covered by other policies?

Mr. JOHNSTON. I want Nancy to comment on that, because she is very concerned.

Chairman STARK. That, in a sense, provides a subminimum wage. If you can hire a kid who is covered by his or her parent's policy, you are hiring that kid at less than an adult if it is a minimum wage job. I presume Medicare beneficiaries would be out from under it, too.

So you have seniors at a subminimum wage or a wage differential. Was that labor's concern?

Ms. MILLS. That was one concern.

I did not mention it in my two concerns about the bill only because I had a commitment on the part of the administration to look into this.

We contend this is going to be impossible to police. How are we going to find out whether your son, daughter or mother has health insurance at another work site? It seems to fly in the face of what was the underlying principle or motivating force on this entire piece of legislation. It was the one on the part of small business that was achieved, that is, someone is paying for this. We needed a fairer system of paying for it. There is no free lunch.

The whole point of this legislation is that one business person and his or her employees ought not to be bearing the costs of those national chains that are not providing health insurance for their employees.

The same thing is true for big business versus small business. I believe we applied that principle very well in almost every area except in this one.

What this boils down to is that the employer who initially provides the health insurance for one member of the family, if he or she provides insurance to the entire family then he or she is picking up the cost that someone else is not picking up. We are worried that it will result in a further erosion of family coverage, which will exacerbate the problem.

Then there is the problem that if you exempt people covered from other programs, will the dollars going into the fund be sufficient to meet the demand. We hope this is an area we will correct in the future.

Chairman STARK. Is there a gap? For instance, if you are not receiving unemployment compensation, if for some reason you do not qualify, then you don't qualify for insurance?

Second, while you don't mandate benefits in this plan, your state, as I understand it, mandates benefits for insurance plans, so that the only people who don't have specified benefits directly or indirectly are those who are in self-insured plans? Isn't that the result?

Mr. JOHNSTON. Yes. But there was an implicit understanding that we would have a basic, sort of a core benefits package which would include most, if not all, of the mandated benefits. The primary mandated ones are substance abuse, mental health and prenatal care. That is what in fact we intend to implement.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Thank you for inviting this panel. I hope you will invite them back in four or five years and we can find out if this program really works and whether it is a vision for America or a nightmare for Massachusetts.

Some of the concerns you expressed, reading between the lines—I am aware of the uncertainties regarding the costs of the program and if they exceed it, what would happen. Furthermore, I want to make sure I have been reading the papers correctly.

My understanding was that the ink was barely dry on this plan when at least one of the parties to the negotiations had an important piece taken away, $17 million for hospitals, correct? It was part of the recent budget package. Wasn't there a substantial amount of money they thought they were going to get as part of their commitment to support this, which was just taken back?

Mr. JOHNSTON. No. That was a totally separate piece of the bill. One piece was the hospital payment and the other was the universal. The hospitals made out very, very well.

Mr. GRADISON. Wasn't there a recent reduction in payments to hospitals?

Mr. JOHNSTON. There is a reduction.

Mr. GRADISON. How much did it amount to? Was it $17 million?

Mr. JOHNSTON. I think in the end it amounted to $13 million.

If one were to look at the entire package that the hospitals received in terms of an increase, it is in the order of $450 million.

Mr. GRADISON. You have 4 more years to go.

Mr. JOHNSTON. This is a very, very generous package to the hospitals. I think there was a consensus that they need it.

That is not $450 million in public funds. Most of the money is private money, not public. The impact on the State budget for this fiscal year was relatively modest, $79 million on the base of a $12 billion budget.

It gets back to the earlier point that there was to be a partnership here, and the business community, employees and government, are paying for this jointly. This is not $450 million in taxpayers' dollars.

Mr. GRADISON. I appreciate the comments of each of you on this, but in view of the experience that you have had and the hard work in putting this on the books and the fact that it differs from the way the first state to have mandated benefits did it, and also taking into account that this doesn't fully become effective until 1992, wouldn't it be better to let the States work this out on their own, rather than having a Federal activity to force States to do something like Massachusetts has done, or at least to wait and see how the Massachusetts plan works out before we inflict it on the rest of the country?

Mr. JOHNSTON. I don't think it is inflicting it on the rest of the country. One can characterize this in any way one chooses in the political scales.

I am telling you the facts. Here you have the first state in the history of the country where we have been able to arrive at a consensus around what the health care delivery system ought to look like over the next few years, involving the business community, government, and labor. Each of those sectors has participated in this effort. They are going to help finance a part of it.

I think with good management, which we certainly have, that we are not only going to have a better health care delivery system in Massachusetts, but it is going to be much fairer in an economic sense, much fairer, in that 600,000 people who today don't have any health insurance—even though two-thirds of them are working out there—are going to have access to high quality health care. That represents a remarkable achievement in Massachusetts.

It is nothing short of a disgrace that in 1988, in the richest society on the face of the Earth, that this subject is even being debated nationally. We should have dealt with this 30 years ago.

As Governor Dukakis points out, it was Harry Truman who made this an issue in 1948. We are still talking about it 40 years later and not much else is happening except in the Commonwealth of Massachusetts.

We think it is high time that the other States have an opportunity to provide high quality health care.

Mr. GRADISON. They have the opportunity. They have not chosen to follow Massachusetts as yet.

My question is, should we continue to let them have the opportunity to make their choice or should we by some Federal action require them to follow—you keep mentioning Massachusetts like it invented the idea. Hawaii was first, right?

Mr. JOHNSTON. Hawaii was originally a plantation economy and a few corporations ran the State economy at that time. Also, they have exemption from the ERISA legislation. None of the other States have an exemption from ERISA. So you have to somehow do the politics within your own State to arrive at the kind of consensus we were able to arrive at in Massachusetts.

This is a postscript to this, and Nancy and Jack might want to comment, but had it not been for the fact that we had an extraordinarily healthy economy in Massachusetts in the last decade or so, I doubt we would have been able to achieve the political support we needed.

Chairman STARK. Would your job have been easier or more difficult if there was a Federal mandate that said by 1990 you have to have it in place?

Mr. JOHNSTON. Easier.

Chairman STARK. I would appreciate your answers.

Mr. COGSWELL. I disagree. I think it would have been harder.

The thing you have in Massachusetts that any Federal edict would not have is a partnership where everybody is committed to try to make it work. If we had people who were not committed to try to make it work, any one of the partners could shoot it down. I think that is a very, very significant difference.

I would agree with you, Mr. Gradison, that the process should be, "Let's see if Massachusetts can make it work," because the pitfalls are immense if it doesn't work. I think, with the partnership we have, we do have the commitment to try to make it work.

Mr. GRADISON. I think it is a major national problem. I hope yours is a success.

I am raising the question of whether we are sure enough that it is going to work to—if you don't like my word "inflict"—then adopt it in the other 48 States. That is an additional policy question, to say nothing of the fact that if you are having all this trouble bringing these different groups together in one State where you have some degree of sharing of values, a compact State with a successful economy and all that, what is it going to be like down here to try to put it together? You may end up with something that is so minimal, you will wonder if we are helping or hurting.

Mr. JOHNSTON. I think the key difference was that there was some executive leadership. You had a Governor who took this seriously, put it at the top of his political agenda and spent an enormous amount of personal time in getting the parties together.

Had that not happened, we would not be sitting here talking about the Health Security Act of 1988 in Massachusetts.

Ms. **Mills**. I would like to comment on that, as well.

I agree, the issue is leadership. It was leadership not just of our Governor, but our legislative leadership as well, who said that this was something that we ought to do, that in our society we should not have children who are not getting care because they do not have insurance, that we should not have people who work for a living not getting care because they do not have insurance.

It was that leadership and many, many years—as a matter of fact, my child was not a gleam in my eye when I started this process, and she is over 2 years old now. It took a lot of time and work, but we were committed to a vision, a vision that people would have health security in this society. I think that is what it is going to take on a national level.

Yes, it may have been easier in Massachusetts because the economy was a healthy one, but doesn't that in fact mean we need it all the more in the other 48 States? In those States there are probably many more people going without care or afraid of walking into that emergency room for fear of being humiliated and embarrassed.

The question is, we take the stand and say in our society, one of the greatest societies on Earth, should we have a society in which people are afraid of getting health care and they must choose between looking after the health of their children and their spouses.

Isn't it the same as the 40-hour-work week and unemployment insurance and Social Security?

I would urge this committee, as well as our other national leaders, to bite the bullet and take the leadership that is necessary and bring us to the bargaining table, all of us—business, labor, small business, government, et cetera—force that partnership. It didn't happen because Jack and I are good folks who enjoy working with each other. We beat our brains in. It is because someone said to us it was in the State's interests, in the people's interests, and I would urge you to pull us to the bargaining table if we don't come willingly.

Many of us do, but it is up to you to pull us there and make sure it happens.

Mr. **Johnston**. The Massachusetts legislation does not necessarily translate into a national bill in its specifics.

I think what we are talking about here is a general approach, a general strategy which we think is important and makes sense. What we are doing in Massachusetts may not apply or it may not work nationally in specific terms, and may not work for State-to-State. Nothing here is written in concrete.

But certainly we think it is an important achievement for our State, and if we can do it in Massachusetts, one would hope it could be done nationally.

Mr. **Gradison**. Thank you.

Chairman **Stark**. I have a quick history here. It has been 70 years since the first national health insurance bill was introduced into Congress with the support of the American Medical Association—wonder of all wonders. They came to their senses 3 years later. The Wagner-Murphy-Dingell bill was proposed in 1948 as part of the Democratic platform. Truman failed in 1951 to get his through and switched to Medicare, which took 15 years. Then Nixon had one, as did Carter in *1980*.

So it is 70 years later and we are still talking about getting this done. At least Massachusetts and Hawaii should get some credit.

Mr. Levin.

Mr. LEVIN. I think the questions from the two of you have provoked and have inspired a most meaningful dialog.

I just want to comment briefly. Mr. Cogswell, I don't think I understood your response when we talked about mandating. You said if there were not the cooperation within Massachusetts, there would not have been the bill that emanated. But if there is not that willingness in the other States, if there is not that activity, there is no bill at all.

The dilemma is that some States, if you just leave it up to the creation of the partnership without a spur from the States, you are going to have this wide variety of reactions, including, in many places, no reaction at all.

We talked earlier about cost shifting among industries, from service industries to industrial sectors. You have similar shifting of costs among the States when you have some States that mandate and others that do not.

One last point. It seems to me, Bill, that the fact one State pioneers I don't think means that the Federal Government never mandates. It seems to me that one of the purposes of having a pilot project or a hothouse kind of atmosphere where a couple of States take the lead is that we learn from it nationally and not just say, well, one State has done it, it has done it well, so we just leave it for every other State to duplicate.

Mr. GRADISON. Would you yield?

Mr. LEVIN. Sure.

Mr. GRADISON. This plan doesn't take effect until 1992. There is a plan, but we don't know how it is going to work.

Mr. LEVIN. How has it worked in Hawaii?

Mr. JOHNSTON. It has worked very well.

Mr. GRADISON. The Governor is not running for President, so I am sure we will not hear much about it.

Mr. LEVIN. When Governor Dukakis becomes President, he will encourage mandating and give the credit to Hawaii.

It seems to me we do tend to take positions or postures politically on this and we ought to remember that this idea of mandating federally with the States implementing it, as you have suggested, I think, with some discretion state-by-state, is not necessarily a Democratic idea. It has some roots in the federalism of the Republican Party, at least in the previous decade.

I think Massachusetts is to be congratulated for its taking the lead along with Hawaii. I hope we take a serious look at mandating and that other States learn from that experience.

Thank you.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

Mr. Cogswell, you represent the Business Roundtable, which is comprised of executives from the State's largest employers. You talked about your experience in Massachusetts exempting the small employers.

Are they represented in your partnership that has been spoken about?

Mr. COGSWELL. They were not in the earlier versions, 3, 4, 5, 6 years ago. But I think Phil described it very well in terms of the package that was crafted in order to provide them incentives to provide insurance to their employees.

One of the problems is the rate shock impact, an 80-cents-an-hour increase in a small business where their profit situation may not allow them to do that. That is one of the concerns we addressed in terms of creating that kind of program.

When you think of a small business, when they go out to get insurance they end up paying significantly higher rates than I do. My business is large enough to get a business rating and a good breadth of risks. But a smaller business has a higher rate. That is a major roadblock.

One of the things that has been done in our bill is to try to create either a combined package that the State would generate in terms of spreading the risk and providing component insurance or incentives through the subsidies for him to go out and do it himself.

Mr. ANTHONY. Are you meeting daily to hammer out this draft legislation in conjunction with the legislative leaders?

Mr. JOHNSTON. The language is worked out. We are in the implementation phase.

Mr. ANTHONY. Do you have representatives from other business groups besides Business Roundtable that participate actively in these discussions?

Mr. COGSWELL. Yes. Officially and unofficially. In developing a pilot program and testing them out with small businesses, using small businesses associated with us, to try to find out what kind of insurance products they are interested in, they are working closely with us.

Mr. ANTHONY. So when you said if any one component part had pulled out, you said if the small business component pulled out and refused to operate, the legislation would not have moved forward?

Mr. COGSWELL. Or it would not have become implemented. There are too many possibilities for gamesmanship.

Mr. JOHNSTON. I was making more of a political point in response to the chairman's question about the politics of this thing.

It gets back to another point he made earlier, which is that obviously people in a legislative body—and you know this better than anybody—are very sensitive to the local merchants, to the filling station owner or the dry cleaning establishment proprietor and so on.

When they were going back to their districts at the beginning of this debate, they kept hearing this was going to be a very serious problem. So we sat down, including the legislature, sat down with many people who were small business people and tried to deal with their issues.

I think we have dealt with many of them, although not all.

Mr. ANTHONY. There will be a witness later who will represent the NFIB. In making a quick perusal of the testimony while you were talking about the experience you had in Massachusetts and the small business problem and big business saying there is a competition situation, as you addressed it, you run into words like "unconditional authorization" to mandated health insurance coverage. I think this witness will be able to agree with this on his own—there doesn't appear to be any given whatsoever in the national small business community in terms of anything that would be happening on a national scene.

I was curious, if that is the national attitude, how were you able to overcome that on a State basis?

Mr. **Johnston**. By dealing with some of the issues with the provisions I cited, hardship trust funds, some tax incentives for small business that have not been providing health insurance and exemptions for up to six employees.

Mr. **Anthony**. So you just kept working with them until they felt they were being treated fairly and their problems were being addressed?

Mr. **Johnston**. Yes. This is an evolving process that will continue over time. This legislation is being implemented through a new department called the Department of Medical Security. The bill just went into effect on July 1. We will be appointing a commissioner within a few days to begin to do this.

This is a 4-year phase-in kind of operation. So we will be relying on people in the business community. We will be working hourly with people in the business community, whether they are small, medium or large businesses, to work out the implementation of this legislation.

Mr. **Cogswell**. I think that is important. The phase-in is critical. Nobody on the business side wanted mandated benefits. When we finally broke through and began to communicate and understand each other's problems and began to address our social responsibility as well as the cost impacts and the direction the whole thing was going, everybody began to make compromises.

There are pieces of the legislation that Phil is not happy with, that Nancy is not happy with, and I am not happy with, but we each made compromises to see it work.

We are going to test it and make adjustments in it where we find places it does not work.

Mr. **Anthony**. Thank you.

Chairman **Stark**. Mr. Coyne.

Mr. **Coyne**. I would yield my time to the other Massachusetts miracle, Representative Donnelly.

Mr. **Donnelly**. Let me apologize to you both for being late. The Boston-Washington air corridor is the busiest in the country and it proved it once again this morning.

Let me welcome you and thank you for coming. There has been a lot of talk about what we did in Massachusetts and I think it is really important that from both the private sector and public sector, the people in Washington have an opportunity to hear about not only the end result but also the whole process to get there.

I, frankly, don't think it was such a revolutionary thing we did. I think the reaction is probably revolutionary or somewhat reactionary, frankly. Isn't it fair to say anybody in Massachusetts or any other State who has an acute illness should be cared for whether or not they have insurance coverage?

Mr. JOHNSTON. Yes. The point has been made several times this morning, somebody is paying for this. We don't let people injured in an automobile accident lie in the street. They end up in municipal hospital emergency rooms, very expensive health care.

In basic, very fundamental ways, it is irrational. We are reorganizing the system in making it, we hope, better managed, more even and more equitable and more accessible.

Mr. DONNELLY. That is the point I wanted to make. If you have an acute illness in this country, you will find the hospital or physician that will provide you the service and somebody will pay. These people don't do it for free.

It will either be the State, county, municipality, Medicaid or Medicare. The end result is the individuals who pay are the taxpayers, individual and corporate, pay to make up for the cost of that service.

I guess the point we miss is we don't provide preventive services, that type of medical care that will prevent an individual from having an acute illness that would cost the taxpayer substantially more money.

The Secretary is correct that we are reshuffling the system to provide a system that is hopefully more cost efficient in the long run. I think we get tied up in the words "mandated benefits". You know when the business community or certain political individuals hear the word "mandated", they have an enormous visceral reaction.

Perhaps you could comment on how in Massachusetts it is not just mandated but it is a cooperative effort. I want to follow up with a question of how we dealt with cost containment in the new universal coverage.

Mr. COGSWELL. We spent almost 8 years working on the project and living through three different bills that have done different things. One of the things it did was to take the cost shift portion of the inpatient care, that is, the free care the hospital loaded on somebody else's bill and they never knew they were paying it, they have put that into a separate pot where people can measure it.

Once they realized how big that $300 million cost shift was, it came to their attention and they were willing to come to the table.

The other thing is that that covers only inpatient care. The carrot is to be an inpatient because you don't get outpatient care. You are not only not getting the preventive care, but you are getting care in the most costly environment you can get it in.

Everybody at the table learned enough about health care and understood it well enough to try to get a partnership together to work on it.

Mr. DONNELLY. Can you say how you dealt with the issue of excess bed capacity and cost containment provisions put in the legislation dealing with universal coverage.

Mr. JOHNSTON. The State of Massachusetts has been between 6,000 and 8,000 too many acute care hospital beds.

Mr. DONNELLY. What percentage of that is total bed capacity?

Mr. JOHNSTON. About 10 percent. It is adding up to $50 per day for hospital costs for the average patient. The legislation creates a hospital conversion board to which hospitals which have low utilization rates can apply for permission to convert to other, more appropriate uses. In other words, to help them move from acute care—this goes back to your point earlier—to convert to more economically appropriate uses.

As an example, we have a hospital now up on the North Shore of Boston which is in very bad trouble because people are not going there because there are other teaching hospitals fairly close by that are more popular for patients.

However, we did not want to lose this health care resource for the community so we encouraged them to apply to the hospital conversion board which they have done.

This is the first hospital we have dealt with under the new process. We said to them, look, we have some major money, public dollars on the mental health side because at the same time we are doing this on the acute care side we are fundamentally reforming our health system and we have a desperate need for acute care beds and mentally ill people, particularly in that part of the State.

We said we will help you, we will help to finance your converting some beds from acute care to this mental health use. They are doing so.

I think we will be able to save this very important health care resource. Also, at the same time we will be getting rid of expensive acute care beds that are no longer needed.

So it is win-win for the hospital and for the taxpayer.

Mr. DONNELLY. This committee cannot but be helped to learn how we deal with that.

Does it make any sense for Massachusetts to be the first, to go it alone?

Mr. JOHNSTON. Somebody has to be the first. Brandeis said States are the laboratories for change. You have seen it on welfare reform legislation which is moving through here, we hope rather quickly.

It was based in part on our experience in Massachusetts over the past few years, the E.T. program, again, it is not being adopted at the Federal level in itself entirely by any means and you have to make allowances from State-to-State and region to region but the principle that we found in doing this welfare reform program in Massachusetts really I think had beneficial lessons for people at the national level.

The point was made in previous testimony that like it or not, this is happening all over the world here. We are slow to respond in this country to this issue. When you have countries, as noted earlier, like South Korea and Japan and most other industrial nations doing this, in a competitive point of view we are not even in the ball game here unless we start to do it on a serious basis nationally.

I think you can look at the Massachusetts experience as part of Brandeis' description of what the States should be, laboratory for change and take parts at the national level that you think makes sense.

At least we hope the problem will be dealt with.

Mr. DONNELLY. Let me ask Jack the same question but expand it a little bit.

One, does it make sense for Massachusetts to go it alone and how does that affect the Massachusetts business community competitive relationship with the neighboring States or any other region in the country?

Second, for Massachusetts-based companies that have operations that are beyond the Massachusetts border, have employees, whether in the New England region or any other in the country, what provisions are there in the legislation that would affect a large employer with employees in and out of State. Those out of State are obviously not covered by the plan.

Mr. **Cogswell**. There are a lot of problems with the multi-State employers. One problem, for example, is the mandate that you cannot provide different benefits for different employees.

If Massachusetts provides something greater than that company is providing throughout the country, it has a problem. From the competitive view of the situation, that is one of our concerns. What affect does it have on jobs, the economy and the business community in terms of how they grow between, let's say, Massachusetts and New Hampshire. One of the lessons of using Massachusetts as a trial is to test that, because whatever happens to Massachusetts relative to its neighboring States is exactly what is going to happen between the United States and its neighboring countries.

To the extent this creates inflation and cost increases, we are going to have the same problem competing with the rest of the countries. When you think of the impact of gamesmanship, the impact of the accounting board saying you have to prefund retiree health care but you cannot get a tax benefit for that, the odds are that the businesses are going to begin to stop providing health care for retirees because that cost is getting too great.

That kind of problem is being assessed in all these mandated health benefits. I think it is good for Massachusetts to try it as a laboratory as Phil mentioned because I think you as a committee and the country in general will learn a lot about how the various pieces react.

There are a lot of unknowns, administrative problems. Phil talks about 600,000 uninsured. The interesting thing is that those 600,000 are different tomorrow than who they are today.

The administrative problem of covering somebody who today is uninsured, tomorrow is Medicaid, and the next day is working insured is a tremendous administrative problem. That whole phase-in to test that has to be played out over the next few years. It is a very exciting prospect to try to develop that program.

Phil, do you have anything?

Mr. **Johnston**. I appreciate the interest of the committee. We hope you will be interested in following the progress of the legislation as we go about implementing it.

We think it is important. We will certainly provide members of the committee with any and all information that you want to receive, and we will work closely with your staff.

Mr. **Donnelly**. It is nice to see Massachusetts No. 1 again on a major social and economic issue. Of course it is not an unusual position for us to go in, Phil.

It is not unusual for the members of the committee to see us in that position.

Having said that, let me just say I think the issue of universal coverage will be one of the main issues in the next Congress. I think the Massachusetts experience is something and the private/public partnership that has taken place to build this legislative initiative is something that will be used to build a national model.

This is not a revolutionary idea. The care is being covered now. Basically what we have done in Massachusetts is make that care orderly and effective, and redistribute the cost. I think it has been redistributed in a fair way.

It is not only the morally correct thing to do. I think it is the fiscally responsible thing to do, if the package is put together properly, so that we can get away from a system where we are reimbursing for bad debt, using money from the payroll tax, the most regressive of all taxes. I can think if many more progressive ways to do it.

Again, I apologize for being late.

Chairman **Stark**. I want to thank the panel very much for sharing their experience. I hope we don't have to wait 4 years to get more input from you as to how this proceeds.

Thank you very much.

Our next panel will be comprised of representatives of the business community, including Arthur Young, the benefits manager for Hewlett-Packard Co.; David Rehr, the assistant director of Federal governmental relations, for the National Federation of Independent Business; and Ronald Dunbar, the executive vice president of Ryder System, Inc., who I believe is speaking on behalf of the National Association of Manufacturers.

I want to apologize to this panel for the Chair's longwindedness and reluctance with the hammer here.

I have been advised they are going to chase us out of here at 1:45 so the Social Security Committee can begin a hearing at 2. I pledge to keep my questioning short.

I don't want to encourage the panel to withhold any information, even though we may be a little limited on questioning.

Would you all care to proceed in the order that I called you?

You may summarize or expand on your testimony or present them in any way you choose.

Mr. Young?

STATEMENT OF ARTHUR YOUNG, BENEFITS MANAGER, HEWLETT-PACKARD CO., ON BEHALF OF THE WASHINGTON BUSINESS GROUP ON HEALTH

Mr. **Young**. My name is Arthur Young. I am employee benefits manager for Hewlett-Packard Co. in Palo Alto, Calif. I am also representing the Washington Business Group on Health.

We have 54,490 employees in the United States. Health care is important to those employees and to the company. Some 32,000 employees and about 70,000 dependents participate in HP's self-insured medical plan.

Another 21,555 employees are members of more than 90 health maintenance organizations, HMO's, that the company offers around the country.

We are paying $2,200 per worker per year on health care. We believe in a number of aspects of the bill, and we have some comments on some aspects—first of all, we support extending the tax deduction to self-employed workers because we think that will broaden the base of coverage.

Second, we are very much in favor of the ERISA preemption against State-mandated benefits. We operate in all 50 States, and many of the States now have mandates.

Operating 50 self-insured plans, as well as 90 HMO's would be a tremendous amount of administrative activity. In many of the States we see requirements to cover specialized provider services such as chiropractic, mental health and so forth.

We are concerned with the high level of mandated benefit coverage the bill proposes. We are seeing more and more single family head-of-household type families in our company, and we are trying to change our type of policies, our medical premiums, and so forth, to allow for things like part-time work.

If we require that 80 percent of the health care costs be paid for part-time workers, it will make it more expensive for companies to provide these alternative type of work schedules. We think that as we face labor shortages in the early 1990's, we are going to need some of these people.

We also have problems with the 80-percent requirement in that when we look at our company coverage, we provide full employee medical and dental coverage. We subsidize most of the dependent medical coverage and part of the dependent dental coverage. If a very strong employer like Hewlett-Packard is that close to the limit—paying 80 percent—we think that will be a problem for some companies.

Another comment we would like to make is we believe that the requirements for signups and levels in this bill need to be looked at in regards to exiting legislation such as the requirements of section 89 of the Internal Revenue Code Integrating these different bills is a problem. So we think that needs to be addressed.

We support the idea of stop-loss coverage, and we have stop loss coverage in our insurance plan. The bill would allow it to go up or be indexed with the CPI.

We think indexing to wages or some combination of the CPI and medical CPI would probably make more sense.

Chairman STARK. Give up on cost controls?

Mr. YOUNG. If the medical costs continue to be high, it will be less meaningful.

We have started to analyze our cost between hospitals, and we notice, for example, that a coronary artery bypass can be $40,000 in one hospital, and $20,000 to $25,000, 10 miles away. We think some gradation needs to be developed there.

We don't have that on in our plan today, but intend to put it in.

Another point I would like to make is we have problems with the specific benefit mandates. In California at any time you have more than 30 health care providers attempting to get mandated coverage for their speciality.

Frequently we see mandates for mental health benefits. We have changed our mental health benefits a few years ago and our costs went up significantly.

We haven't taken—while we are opposed to mandates, we have not taken a position about universal coverage because we are not sure we understand what impact that will have on us long term.

We can't support the proposal to require employers to fund the excess premiums. We think there needs to be some sort of proration or offset so that the bill is fair and so that it doesn't penalize people who are providing coverage. To recap our positions, we support 100-percent deductibility for self-employed.

We strongly support a Federal preemption of State benefit mandates. We support flexibility in designing a stop-loss provision and actuarial equivalents. We support modified provisions for coordination of benefits, needs to be addressed in terms of actuarial equivalents.

We support improved access for employees of small firms and a balancing of actual costs. We support cost-effective purchasing. And we oppose specification of benefits design and mandates that limit a company's ability to design a plan that encourages employees self-interest in purchasing self care.

Thank you for permitting me to testify. I wish you success in getting a bill.

[The statement of Mr. Young follows:]

TESTIMONY OF
ARTHUR YOUNG
HEWLETT-PACKARD COMPANY

My name is Arthur Young. I am Employee Benefits Manager for Hewlett-Packard Company in Palo Alto, California. I am also representing the Washington Business Group on Health. Hewlett-Packard thanks the Chairman and Committee for inviting me to appear today to talk about H.R. 4951, the Employee Health Benefit Improvement Act of 1988.

Hewlett-Packard has 54,490 employees in the United States. Health care is important to those employees and to the company. Some 32,000 employees and about 70,000 dependents participate in HP's self-insured medical plan. Another 21,555 employees are members of more than 90 health maintenance organizations (HMO's) that the company offers around the country.

Gaining reliable access for the current uninsured is an important national priority. So is the effective management of health care costs and the provision of good value to employees. HP's health care costs per worker have increased from about $400 per year in 1972 to about $2,200 per worker this year. Corporations have been key forces in health management. Assisting those efforts -- not impeding them -- should be a national priority. HP believes that all employees should be able to afford the same benefits.

Mr. Chairman, it pleases me to begin by stating that Hewlett-Packard is in concert with large parts of your bill, H.R. 4951. There are a few -- but important -- provisions that cause us concern, and others that we could support with modifications. The HP health plan exemplifies the effectiveness of two earlier federal incentives: the 1948 NLRB ruling with IRS codification, permitting employers to deduct the costs of health care insurance for their employees; and the more recent Employee Retirement Income Security Act (ERISA) preemption that exempts self-insured companies from complying with state mandates, such as those requiring specific benefit coverage.

1. Hewlett-Packard Company supports your proposal to extend the 100% health benefits tax deduction to self-employed workers.

Extending that full tax-deductibility for the self-employed recognizes the importance of entrepreneurship to our country and corrects an eminently unfair discrimination. This provision will broaden the base of people covered by health insurance and help reduce the uncompensated care problem in the U.S.

2. Hewlett-Packard Company is very much in support of your amendment to H.R. 4951 that maintains the ERISA pre-emption against state-mandated benefits.

HP operates in all 50 states. The administrative burden of operating 50 different health plans, along with some 90 HMO's, would be tremendous, if not impossible. In addition, mandates in many states require coverage of specific health care provider services, such as chiropractic care or osteopathy. With an excess of providers in this country, that kind of provision can greatly increase the costs of medical care without improving necessary health care.

3. Hewlett-Packard is concerned that the high level of mandated benefit coverage in your bill will tie the company's hands in molding a benefits package that meets the needs of employees.

Historically, benefit design has focused on the modular family unit: employee, family and children. This benefit design has come under question because of changing demographics -- particularly the single parent family and the two-worker family. A single-parent worker, for example, may find far greater benefit value in dependent coverage than would a two-wage family with double coverage. As a benefit manager, I must respond to needs like these without compromising the company's competitive strength. Flexibility in benefit design permits accommodation of these various needs.

I am struck by a parallel between a high concentration of single-parent families among the uninsured and HP's internal need to tailor different benefits for single-parent families. COBRA was expected to address the needs of this group. It has helped some, but has probably raised costs more than the benefit it has provided. Unintended consequences can overwhelm the good that is done. HP has a reputation for accommodating different family situations through flexible benefit packages, like paid-time-off and leave-of-absence policies. One of the most positively perceived benefits that most employees have had for many years is a flexible work schedule. A number of years ago, HP changed its time-off policies to provide flexible paid-time-off, incorporating vacation and sick leave, and encouraginng people to use flexible time-off for family needs.

Recently HP has been looking at the whole area of part-time employement and part-time workers. We think a worker shortage in the early 1990's will create a new need to get more people into the work force. Part-time arrangements will permit these new employees to contribute to the company and to society and still have time to care for their families. HP will need to pro-rate benefits like time-off and medical coverage to permit this employment flexibility without increasing company costs.

As you define a health care bill to provide universal coverage, I hope you will maintain some flexiblity for employers to tailor programs to meet the needs of different family situations. Companies should be able to change the balance of their health plans to reflect the changing demographics of the family unit. Employers should be able to keep pace with changing employment and employee work patterns by permitting some kind of pro-ration of premiums that will level employee costs per hour worked.

4. Hewlett-Packard Company believes the requirement that the employer pay 80% of the health care premium needs to be reduced.

HP offers very comprehensive health care coverage. Indeed, the company provides medical and dental coverage at no cost to regular full-time employees. The company pays for most of the dependent medical costs and a share of dependent dental costs. The total HP premium breaks down to 81% employer-paid and 19% employee paid.

Despite the fact that the 80-20 copayment requirement does not exceed HP's arrangement, the company cannot support the enactment of such a provision into law. Such a measure would limit an employer's options in a) balancing an overall employee benefits program; and b) getting employee cooperation and participation in efforts to reduce medical costs. If the Committee finds it necessary to mandate a co-payment level, it should be at a much lower level, perhaps 50-50.

5. Hewlett-Packard Company believes that the requirements of this bill must be meshed with those in existing legislation, such as the HMO Act and the IRS Section 89 tests, for simplification of administration.

Along with many other employers, HP is trying to understand the implications of Section 89 anti-discrimination tests: what those rules will be, and how HP will test its plans. It's not clear to me, for example, how that process will relate to the equal payment requirements of the HMO Act. The 80-20 co-payment requirement of H.R. 4951 could further muddy the waters. In another area, the certification process in H.R. 4951 may provide a different set of rules for determining employee coverage than is currently set out in Section 89.

It's important to simplify the administration of these programs by assuring integration of all three. Layering a new set of rules on top of the existing sets will be confusing and potentially expensive for employers to administer.

6. Hewlett-Packard supports the idea of stop-loss coverage that protects employees against major medical expenses, but would urge some modification of the provision in this bill.

HP maintains a stop-loss plan limit in the self-insured plan for both individuals and families on an annual basis.

The bill suggests that the stop-loss could be increased at rates equal to the consumer price index. We think this is too low. The medical price index has been increasing at a rate significantly faster than the consumer price index. Linking the limit to the CPI over time will reduce its effect.

If the medical price index is considered to be too high, some compromise might be possible. For example, averaging the two indices might be reasonable. Another alternative would tie stop-loss increases to wage increases.

7. Hewlett-Packard Company believes that a universal health care bill must allow for incentives for employees to use health care wisely and efficiently.

If we're going to be able to get a handle on the escalating medical costs, companies need to be able to look at the whole area of coordination of benefits in two-earner families. The growing number of dual-income families in the U.S. appears to be leading to a phenomenon of 100% health care coverage. Many companies have established a carve-out type of approach, where there are some shared costs even where two plans are present. This is an important incentive to encourage people to avoid over-utilization of health care services.

HP and other companies also offer financial incentives for people to use out-patient surgery, to go to Preferred Provider Organizations (PPOs), to use efficient institutions, and so forth. We want to have the flexibility to make further changes as we learn more and more specifics about our costs. The bill's actuarial equivalent standards should specifically permit companies to continue those kinds of incentives.

The stop-loss provision must also be modified to include incentives. In the San Francisco Bay Area, certain high-cost procedures in some hospitals are as much as $10,000 to $15,000 more than other hospitals -- or 2 to 2 1/2 times as expensive. A single stop-loss limit neutralizes the ability to influence people to move from one institution to another, since the employee cost is the same in either case. While HP has no current provision that would permit different stop-loss limits at different institutions, we think that capability should be part of any bill.

HP is beginning to collect more information about health care costs. Companies are starting to establish mechanisms that will enable pools of employers to share information and build a data base with health care provider profiles. Employees will be able to compare data about various providers to determine the most efficient approach to getting the care they need. The cost-comparison approach is likely to become more important in the future. Its relationship to a stop-loss provision must be considered.

In our plan alone, HP has instituted more than 30 changes over the last 5 years. Some of these changes have worked. For example, HP provided incentives for people to have out-patient done, and the percentage of out-patient surgeries has indeed increased. HP formed some PPO alliances with El Camino Hospital in Mountain View, CCN in the San Diego area, and others elsewhere. In evaluating our costs, it looks like we saved -- in some cases reducing hospital rates as well as increasing the rate of out-patient services.

HP has done some other things that haven't worked so well. We had a second opinion program with financial incentives that increased costs and found that surgery was necessary 95% of the time. We eliminated that provision.

We also changed our mental health provisions several years ago to provide more frequent out-patient visits and to require pre-certification and concurrent review on in-patient stays. The hope was that we would provide a broader out-patient coverage for people who needed care without increasing costs -- by managing hospital stays better. In fact, our costs have increased dramatically .

The point is that companies will make more changes -- in their own, their employees', and the national interest. We want to make sure that whichever actuarially equivalent standards are applied in a bill allow for change and experimentation without penalty. It will become more important in the future for companies to try alternative health care financing arrangements.

8. As indicated above, Hewlett-Packard Company strongly opposes any specific benefit mandates.

In California alone, in any given recent year there can be found as many as 30 mandates for health care. Providing mandatory coverage -- even for important services like prenatal care -- sets a dangerous precedent that encourages other service providers to lobby for the inclusion of their particular skills. Mandates are not likely to lower or contain costs. More likely, they will encourage even more expensive supply of services that might be desired by some but are not necessary.

9. In contrast, however, Hewlett-Packard is neutral to the idea of mandating universal coverage, as long as it does not mandate specific converage.

HP understands the predicament of small employers trying to control costs. At the same time, we understand the difficulty of nearly 37 million Americans not having health care insurance. One way to tackle the dilemma might be a compromise that would permit smaller companies to provide lower-level, catastrophic care plans.

Recent studies from the Bureau of Labor Statistics may indicate that the coverage problem is not so significant as the 37 million uninsured Americans statistic suggests. The BLS studies show that the ratio of households' out-of-pocket costs for health care in this country has decreased from 5.9 percent in 1972 to 4.7 percent in 1986. The Committee should consider this fact as it contemplates an overhaul of the health-care system. Further study is needed to determine whether this is due to decreased costs to patients or decreased access to health care. If it is the former, the national need would be met if there were universal catastrophic care.

10. Finally, Hewlett-Packard Company cannot support the proposal to require employers to fund the excess premiums for health risk pools.

Employers who provide coverage should not have to pay again through participation in risk pools. Pool losses should be billed to a broader base than just the employers who are already providing insurance coverage. Stated another way, you shouldn't penalize the responsible employers who are doing what you want.

To recap our position, Hewlett-Packard Company supports --

-- 100 percent tax deductibility for the self-employed;
-- Federal pre-emption of state benefit mandates;
-- a flexible stop-loss coverage provision; and
-- flexibility in actuarial equivalence.

Hewlett-Packard would support modified provisions for --

-- benefit coordination in two-wage earner families;
-- improved access to coverage for employees of small firms;
-- balancing of hourly cost coverage for part-time workers; and
-- employee/employer cost-effective health care purchasing.

Hewlett-Packard opposes --

- -- specifics of benefit design
- -- mandates that limit a company's ability to design a plan that encourages employee self-interest in purchasing health care coverage

Thank you again for permitting me to testify. I wish you success in achieving a bill that all of us can support. To the extent that Hewlett-Packard can be helpful to you and your staff members in this endeavor, I offer you my continued involvement as desirable.

Chairman STARK. Mr. Rehr.

STATEMENT OF DAVID K. REHR, ASSISTANT DIRECTOR OF FEDERAL GOVERNMENTAL RELATIONS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

Mr. REHR. I would like to thank the subcommittee for the opportunity to present the views of small business on the issue of mandated health insurance.

While I am not an expert on the health care industry, I will direct my comments to the attitudes and economic realities of the small business community and the small business owner.

As you may know, NFIB is the Nation's largest small business advocacy group, representing more than 500,000 members who in turn employee over 7 million workers. The average NFIB member typically has fewer than 10 employees and has an average annual gross sales of around $350,000.

NFIB's membership by standard industrial classification parallels the overall composition of the Nation's small business community.

Before going directly to my summary of the testimony, I would like to request that the committee insert the complete statement in the record and allow an addition of an appendix which you should now have.

Chairman STARK. Without objection.

Mr. REHR. My summary of the testimony before you will emphasize four key issues which focus on the impact H.R. 4951 will have on the small business community. These issues are, one, the commitment the small business community has made to provide health insurance.

Two, the obstacles faced by small businesses in providing health insurance.

Three, the need to maintain a flexibility of choice for both employees and employers.

And four, positive recommendations to reduce the number of uninsured small business owners as well as employees without adopting mandates.

Issue 1, the commitment of small business to provide health insurance has strengthened. A 1986 survey by the NFIB foundation revealed the number of small businesses providing some form of health insurance has steadily increased to 65 percent in 1986. That is up 8 percent over 8 years.

A random NFIB field survey in April 1987 found as many as 75 percent of those providing fringe benefits were providing health insurance. This increase in coverage exists despite the fact that the median monthly health insurance premium has more than doubled in the last 7 years.

This commitment to provide health insurance is part of the compensation package makes economic sense for the small business owner and meets a social objective, provided the relevant market conditions make it feasible to do so.

The December 1985 NFIB publication, Small Business Employee Benefits outlines the succession of benefits offered to employees as business conditions improve. First, paid vacations; second, health insurance; third, paid sick leave; fourth life insurance; and so on down the line.

We believe the best course to foster insurance availability in small businesses and for their employees would center on efforts to cast government policy which increases the profitability of small business itself.

Issue 2, what are the obstacles faced in providing health insurance to employees? The most directly cited reason for not providing reason is bunched around the cost issue.

Specifically, reasons cited include premium expenses, employee turnover and staff size too small to qualify for group coverage. Small business health insurance premiums, according to estimates by the Health Insurance Association of America, run 15 to 25 percent higher than those of large, nonself-insured firms.

The SBA has estimated health insurance costs for small businesses to be as high as 40 percent more than their big business counterparts. This disincentive is further complicated by the fact that small businesses generally pay a larger proportion of each premium, meaning that when coverage is offered, the small business owner pays more.

In addition, small firms usually lack economies of scale, might face adverse selection, or often are often more instable and lack expertise in selecting insurance plans. These problems exist even in a competitive market environment.

Small business generally use a variety of cost containment devices to make their plans more affordable. Higher deductibles is a common example. By increasing the cost of health insurance as passage of H.R. 4951 will, the situation will only be made worse and not better for small business employees. In its current form, the bill has no built in incentives to minimize insurance costs.

Issue 3, maintaining a flexible choice for employees and employers. Given the fact that we live in a world of economic scarcity, and employees total compensation package is in effect a "zero sum" gain.

Mandating health benefits would have to be offset with other parts of package. Employees who make the subjective valuation that they prefer increased cash to mandated benefits will no longer have this option.

Still other employees preferring to work flexible time, receive life insurance or paid vacations in lieu of other benefits will no longer be able to exercise that option. Such rigidity will hurt individuals who need or desire special working arrangements.

The Bureau of National Affairs recently cited an example which incidentally took place in Massachusetts, on how this flexibility with regard to benefits works in the marketplace.

I would like to bring this to the attention of the subcommittee and request that it be placed in the record.

Issue 4, NFIB supports positive recommendations to help solve the problem of the uninsured. Even with enactment of H.R. 4951, nearly 20 million of the estimated 32 to 37 million uninsured would not be affected.

However, two components of the bill which should stand alone and separate could cover the currently uninsured 1.6 million proprietors and 6 to 7 million small business employees. NFIB strongly supports the 100 percent deductibility and the State-mandated preemption as positive solutions.

I understand you, Congressman Stark, introduced a 100-percent deductibility bill, and I want to commend you for it. Both 100-percent deductibility and State-mandated preemption could be enacted with reasonable speed at a much lower cost to the Government than mandated health insurance.

Passage of H.R. 4951 would curb job creation, stifle business startups and result in lower economic growth.

Obviously, this issue is extraordinarily complex. Small business has made an attempt to provide insurance when feasible in the marketplace, however, the imposition of mandated benefits will only compound economic difficulties by small firms especially marginal ones.

Therefore, NFIB and the small business community vigorously opposes H.R. 4951.

I would like to thank you for the opportunity to testify, and I look forward to answering questions.

[The statement of Mr. Rehr follows:]

NFIB

National Federation of
Independent Business

STATEMENT OF

DAVID K. REHR
ASSISTANT DIRECTOR OF
FEDERAL GOVERNMENTAL RELATIONS, HOUSE

OF THE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: House Ways and Means Subcommittee on Health

Subject: H.R. 4951

Date: August 9, 1988

Mr. Chairman, my name is David Rehr, and I am the Assistant Director for Federal Governmental Relations, House, for the National Federation of Independent Business. NFIB is a voluntary membership organization with over 500,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile.

I appreciate this opportunity to testify on your proposal mandating health insurance coverage to employees of small firms. Clearly, for NFIB members and their more than 7 million employees, much is a stake in the current debate over mandating health benefits. For the record, our recent polling on this issue (April 1987) found an overwhelming eighty-nine percent of our membership opposed to this type of federal policy (7 percent were supportive and 4 percent undecided). Eighty-nine percent of the membership also oppose a state mandate to provide catastrophic coverage as a part of their health insurance plans.

While NFIB is a recognized authority on small business, I am not an expert in the health care industry or in the insurance industry, therefore my remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community that are relevant here. First, I will summarize some of the results of our survey material, then I will briefly discuss the implications of H.R. 4915 from a small business point of view.

The primary basis for my remarks comes from two national surveys we have conducted in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits. In addition, the rising cost of health insurance was the number one problem as reported in NFIB's 1986 Small Business Problems and Priorities and one of the top concerns raised by the 1986 White House Conference on Small Business. This is an area of intense concern for the small business community.

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The Guardian of
Small Business

Background

Despite claims to the contrary, the United States spends an enormous amount of money on health care. In 1987, almost $500 billion was spent on health care, or an average of $1,837 per citizen -- a significant increase of 8.9% over 1986 and an astonishing 11.2 percent of GNP. A number of health analysts predict that as much as 15 percent could be spent by the year 2000, a huge increase especially considering that in 1950 only 4.4% of GNP was allocated to health care.

This trend reflects the spiraling increase in health care costs over the past three decades. Since 1966, health care costs have increased three times faster than the consumer price index and, even more astonishing, health care inflation during the past year has topped 7%. Inflation, however, is not the only culprit. A recent US Department of Health and Human Services study indicated that "35% of the increase in total dollars spent on health care was attributable to the consumption of more service per capita and a higher intensity of service in each contact". H.R. 4951 and its counterpart in the Senate would exacerbate this situation in three direct ways: first, by increasing consumer demand for health care by providing access to care at below market price; second, by forcing the nation to make an even greater commitment of resources to health care, thereby diverting resources from other areas of the economy, and third, by driving up health care costs for American businesses, particularly small businesses, hurting their competitiveness and job potential.

Small business is responsible for creating 70% of the 14 million net new jobs created during the past decade. This tremendous growth has resulted because of the free enterprise system fostered in the United States -- a system free of mandates. While it is true that all industrialized democracies already provide a higher level of mandated fringe benefits than the United States -- these same Western European countries combined have created less than 2 million jobs since 1970, compared to 30 million new America jobs created during the same period of time. Since 1980, Europe has actually lost jobs while we continue to create them. Following the European model of mandated fringe benefits is clearly not an economically prosperous course to take. Contrary to statements made before this Congress, the issue of job creation and international competitiveness does not affect only those business involved in international trade; the issue also strikes middle America -- the stronghold of small business.

The uninsured population has been estimated to be in the area of 32 to 37 million. Of this, 17 million are nonworkers, 3.7 million are individuals seeking employment, and thousands are employees of Congress and the national government who would be exempted from coverage by this bill -- a total well over 20 million who would not be reached by this legislation. Of the remaining 10 to 17 million, 1.6 million are sole proprietors and, according to the Office of Advocacy in the Small Business Administration, approximately 6 million are workers employed by small businesses. It is by no means a foregone conclusion that mandating health insurance will successfully address the needs of the vast majority of the uninsured.

A 1986 survey by the NFIB Foundation, entitled Small Business Employee Benefits, revealed that the number of small business owners providing employee health insurance has been steadily rising, though the proportion of small business employees covered remains significantly less than the proportion covered in large and mid-sized enterprises. Sixty-five percent of small businesses offered health insurance for at least some fulltime employees. This increase was most notable in firms involved in financial services, professional services, retail, and the smaller firms -- the very same firms held responsible for the alleged increase in the uninsured population. During the same period of time, the troubled agricultural sector was the only sector that reduced coverage.

Well over 80% of the health insurance plans offered in small firms carried an option for dependent coverage, however, fewer part-time employees were offered coverage and only after a vesting period with the firm. Subsequent NFIB field survey data from April, 1987 indicate as many as seventy-five percent of those providing fringe benefits are providing health insurance. This is despite the fact that in 1985, the median monthly health insurance premium paid by small employers was more than double the premium in 1978.

It can be observed that the largest firms were no more inclined to provide health insurance in 1985 than they were in 1978, and perhaps even a little less. By elimination, the smallest firms were left to account for the greatest coverage. To understand our unconditional opposition to mandated health insurance coverage, a little historical background is valuable, especially set against the above background which demonstrates that small business is indeed responding to the demand for health insurance coverage.

Small businesses tend to offer a hierarchy of benefits which expands as the firm matures and size increases. Small business owners, as a group, provide their employees with a wide variety of benefits, paid vacations and health insurance being the two most commonly offered. In addition, larger small firms are most likely to provide a wider selection of benefits to a larger number of employees than are the smallest firms.

No single reason dominates a small firm's decision not to offer health benefits. The most frequently cited reasons for not providing health care coverage to all employees were: premium expense, employee turnover too great, generally covered under a spouse or parent policy (secondary wage earners), firm insufficiently profitable, and cannot qualify for a group policy. Each of these will be explored separately.

Premium Cost

Health insurance costs are expensive and increasing. According to recent Health Insurance Association of America (HIAA) estimates for 1988, premiums in small firms run 15 to 25 percent higher than those of large non-self-insured firms. The Small Business Administration estimates costs for small firms can be as much as 40% higher than their larger counterparts. Part of the reason small employers face high health insurance costs is that more than two-thirds pay the entire premium and a whopping 87% pay more than half. In addition, small employers are more generous than large employers when family plans are offered. According to the Small Business Administration, of those firms offering family health insurance plans, 70 percent of the very small firms (1-9) and 55 percent of 10-24 employee firms, but only 34-35 percent of larger firms, pay the entire premium for family coverage.

The cost/benefit ratio for small firms is also skewed against small firms. Of each $100 paid in premiums, small firms derive only $75 in benefits, whereas large firms receive $95 (Nexon, 1987). The reasons for such a differential in both the benefits ratio and higher premium costs include: lack of economies of scale, cost of administration, insurer fear of adverse risk selection, instability in the firm, and the lack of expert help in selecting insurance plans.

High voluntary health premiums coupled with the involuntary benefits of Social Security consume a very significant portion of a small firm's capital. H.R. 4951 will double or triple costs in those firms providing insurance. Estimates of the Kennedy proposal range from the conservative of $1835 per family (CBO 6/5/87) to the realistic $2892 per family (IRET 7/8/87). A chart of these cost comparisons appears in the appendix. These costs are significant, especially in marginal or start-up firms.

Cost containment practices are also not prevalent in small firms, but common methods used to control costs include higher deductibles and/or inclusion or exclusion of employees after a probationary period with the firm. All three options are eliminated by H.R. 4915. Deductible levels are frozen at no more than 20% up to a maximum out-of-pocket cap, all employees must be covered, and vesting periods are prohibited.

Further increasing the cost to the small business employer are the provisions mandating immediate coverage for pre-existing conditions and "paid COBRA". Forcing small firms to immediately include persons having pre-existing conditions under their plans will translate into higher insurance premiums due to the phenomenon of adverse selection. Even more threatening to small firms is the "paid COBRA" provision. Small business has been upset with the COBRA provisions since they were first enacted in 1985 without benefit of hearings or input from the business community. Costs to small businesses with the enactment of a COBRA, where premiums are paid by the employee, have skyrocketed. Forcing small businesses to pick up the entire premium cost for the first two months will drive those costs through the roof.

Additionally, a recent survey of corporate benefits plans conducted by Towers, Perrin, Forster and Crosby concluded that nearly 65% of corporate plans currently in place would not be in compliance with the levels mandated by the very similar S. 1265. The cost of rewriting those plans to meet federal requirements could well exceed $50 billion dollars. Even America's largest domestic employer, the U.S. government, does not offer insurance to its agency employees which meet the specifications of either S. 1265 or this bill.

While exact comparisons between the proposed federal plan and policies held by small firms cannot be made, based upon prior research it is safe to say that the vast majority of the policies held by small firms would not meet the new federal requirements, particularly the more specialized care provisions now in the bill and those that will be inevitably proposed by special interest medical lobbies. As more services are added to the minimum package, costs will escalate. The experience with state mandates demonstrates this quite accurately.

Clearly, the mandated benefits package would cost business more than expected health outlays for 1988 due to higher premiums, low deductibles, and capped copay. One obvious impact of higher health premium cost will be less monetary compensation for employees as small firms shift funds from cash compensation or other fringe benefits to health insurance premium payments. Another consequence of increased payroll costs could be a reduction in the size of the firm's workforce with lower skilled and/or entry level positions cut first. Such workforce reductions would hurt the lower income, women, students, and elderly who are employed in large numbers by small businesses.

High Turnover and Part-Time Employees

Small firms are labor intensive. High employee turnover is commonplace, as is the use of part-time employees. Under this proposal, high turnover rates will drive up administrative costs and increase the employer's COBRA liability -- both contributing to higher premiums. Also of concern to the small business community, which tends to offer coverage to more part-time employees than do larger firms, is the 17.5 hour per week part-time definition. This definition, landing out of thin air during the COBRA debates, is much too low. Common sense and standard industry practices show that this number is completely arbitrary -- the average part-time worker is on the job 22 to 30 hours a week, not 17.5. Mandated coverage to 17.5 hour per week employees would significantly drive up the costs for many employers who hire large numbers of part-timers in order to retain flexibility to staff their firms to meet peak work flow needs. Because of the significant costs involved, mandating coverage may result in the loss of many of these jobs and jeopardize the "first-time" job experience 2 out of 3 people get in a small firm.

Coverage and State Risk Pools

Small business owners purchase private health insurance from a great variety of carriers However, self insurance remains an option rarely exercised despite the obvious advantage of exemption from costly state mandates.

There is a significant trend toward trade/business association sponsorship of plans. This trend can be directly tied to increasing employee health coverage in small firms. The NFIB group health plan, underwritten by State Mutual, has been very successful in providing coverage for smaller and often less affluent firms. Despite the trend, many small businesses are still unable to obtain reasonably priced insurance coverage due to the firm's small size and marginal profitability. Even our own association plan requires firms to have been in business for 13 months to be eligible to apply, due to the extreme voliatility of small firms.

Regional carrier system and mandatory participation requirements virtually lock out private sector competition and place the national government in the precarious positions of passing out monopoly rights to the select few insurance companies who would underwrite the pools.

High risk or general eligibility risk pools are not supported by small business and have been firmly rejected by NFIB as alternative insurers. The inherent problems with general eligibility risk pools, such as proposed by H.R. 4915, is both their tendency to provide cross subsidization among participants forcing "healthy" participants to pay higher than necessary premiums, and their tendency to be unstable as the pool becomes more and more high-risk-group oriented. Another concern is that reasonable premiums will not be available. Inadequate insurer volume or economies of scale are not the cause of high premiums; high rates for small firms are directly tied to the nature of the firm itself -- small size, high turnover, labor intensive operation, and little expertise on health care management.

In addition, constant supervision by the national government may be necessary to ensure the pools are properly managed and maintained -- at obviously greater costs. There is also the possibility that pools saddled with marginal firms will seek government assistance to meet their obligations -- again at considerable costs.

Current Tax Law and Health Insurance Costs

Surprisingly, the most influential body of law in the health insurance industry is the tax code. Tax policy toward health care has taken some odd twists and turns during the last few years. Health insurance is generally available in one of three ways: purchased privately from the insurance company, purchased through an employer-sponsored plan, or purchased through some group arrangement, such as the American Association of Retired Persons or NFIB.

The difference between the three avenues available to individuals who wish to purchase health insurance is best illustrated by comparing net costs to the employee in each case.

Example A:

An individual contracts privately with an insurance company for health insurance. His cost is $250 per month, totalling $3,000 per year after tax; factoring in income taxes, his net cost is $3,450.

Example B:

Presume the individual can join a group which provides roughly equivalent coverage but at a rate 20% lower than the individual can individually contract for. His cost after tax becomes $2,400 per year. Factoring in income taxes at a 15% tax rate, his net cost is $2,760.

Example C:

Presume the individual begins work for an employer with roughly equivalent coverage, but the employer pays 70% of the cost of the health insurance. Factoring in income taxes at a 15% tax rate, his net cost is $828.

These examples do not consider the possibility that the individual employee may be entitled to some tax deduction for health insurance as a personal itemized deduction. However, this tax benefit is quite limited, as the individual can only deduct health costs in excess of 7.5% of his adjusted gross income -- a rare occurrence.

It does not require great statistical analysis to realize that the most beneficial manner for an employee to purchase health insurance is through his employer. Most employees do not consider the employer's cost of the health insurance as a part of their compensation since they never see it. The true cost of employment borne by each employer is frequently hidden, thereby giving the impression that compensation is significantly less than it truly is. Adding salary and wages plus taxes plus fringe benefits plus government-mandated benefits, such as Social Security, puts the whole issue in a new light for the employee.

Tax Assistance to Low Income Employees

H.R. 4951 includes a proposal for low-income employees who contribute to an employer's health plan. Eligible individuals could obtain a tax credit to be used to purchase health insurance. The credit would be paid to the employer, who would remit the credit on a regular basis to the employee, allegedly to be applied by the employee to his/her share of the health premium as the premium comes due.

Small business owners are already forced by state and federal governments to police many aspects of the daily lives of their employees. This proposal would result in increased involvement, with the employer having to certify and document qualified employees for federal reimbursement. In turn the employer would have to maintain the paperwork and would be held liable for any misrepresentations. This is a complex process at best, further complicated when an individual leaves the firm and becomes eligible for COBRA benefits. Further, the employer is refunded by the government for the advances made to the employees only at tax time --an ongoing threat to a small firm's cash flow.

100% Deductibility and State Mandate Preemption

In spite of the small business community's adamant opposition to H.R. 4915 and to any legislation advocating mandatory health insurance, there are two provisions contained in this legislation which represent significant accomplishments on the part of this Committee.

One is the permanent institution of 100% deductibility of health insurance premiums for the self-employed. The tax laws give a distinct advantage to the business owner who operates in the corporate form as opposed to the business owner who operates as a sole proprietor or partner. In the corporate form, the owner's full health insurance costs, as well as those of his employees, are deductible as business expenses, while for the self-employed, only the health insurance costs attributable to the employees are fully deductible.

The Tax Reform Act of 1986 made a move in the right direction by allowing 25 percent of the cost of the self-employed employer's health insurance costs to be deductible. However, this partial and temporary deduction denies the self-employed business owner the incentives given to the corporate business owner to obtain health insurance.

According to a 1985 study by the Employment Benefits Research Institute (EBRI), forty-two percent of self-employed business owners carry no health insurance. These business owners make up sixteen percent of all uninsured workers. Full deductibility, therefore, would address a significant portion of the health insurance gap that exits simply by equalizing the treatment for incorporated and unincorporated businesses.

Mr. Chairman, your bill, introduced last week, addresses this problem of the uninsured self-employed workers by increasing their deduction for the cost of health insurance to 100 percent. NFIB applauds your efforts to eliminate the current unwarranted discrimination against self-employed business owners.

Second, NFIB supports the provision calling for federal preemption of state mandates. NFIB does not believe mandating benefits at the federal or state level is prudent public policy. State mandates for specific types of benefit coverage now number over 600. These state mandates have seldom surfaced as a result of constituent demand, but rather have been initiated by well-organized special interest groups, including the providers of services themselves.

The end result of benefit mandates in many states has been a remarkable growth in the number of providers performing the mandated service -- providers who suddenly find that payment for all services is available, indeed mandated, by state law. In Wisconsin, the passage of a mental health mandate resulted in a phenomenal rate of growth in the number of outpatient mental health clinics -- from less than 40 to more than 900 in ten years.

In Maryland, state-mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross & Blue Shield coverage by more than 11% in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4%. Mandates eliminate the cost control mechanisms provided by comparative choice and increase the cost of health services.

Benefit mandates make coverage out-of-reach due to the legislative dictates of the package's components. They take away the right of the insurance purchaser to select and pay for coverages based on the needs of the work force and the ability to pay. Instead, buyers end up spending scarce resources on benefits that they may not want or use, or reducing coverage for more essential health services in order to accommodate the extra costs associated with mandates.

The state mandate provision contained in this bill is one important option for reducing the cost of health insurance to small employers. However, NFIB's support for the above-mentioned provisions does not in any way indicate our support or endorsement of H.R. 4915.

Conclusion

Quite simply, Mr. Chairman, there are ways to encourage the expansion of health insurance coverage to employees of small firms, other than mandating coverage. A better alternative is to put small business on a footing more equal with their larger competitors -- equalize the health insurance premium deduction, provide equal protection from state benefit mandates, and explore offering more workable incentives to small firms including expanded tax incentives.

Much of the problem, though, is structural. First, we have just been through a period of record numbers of new business startups. Those marginal firms coupled with firms that leave the marketplace make up a significant portion of the small business community, roughly 20% at any given time, who are unable financially to provide significant fringe benefit packages.

Second, health insurers do not want to cover these new firms. As mentioned previously, even NFIB's group policy underwriting requirements have to recognize the marginal status of new firms. The data we have indicate small employers provide health insurance benefits when they are financially able. Small firms are responding to workforce pressures to provide benefits comparable to large corporations. The small firm, however, must be given the flexibility to phase-in those benefits as the firm matures and becomes more profitable.

I would reiterate that small employers continue to offer health insurance, but it must be affordable. They are the true victims of a health care cost crisis. That's the problem, Mr. Chairman -- not the small entrepreneur who is risking everything in the marketplace and providing jobs that wouldn't exist otherwise.

vas/6220D

COMPENSATION

Compensation Plans

MORE PAY, REDUCED BENEFITS ATTRACTS PART-TIMERS TO MASSACHUSETTS BANK

Berkshire County Savings Bank, Pittsfield, Mass., was having a "very hard time getting part-time help," but solved its problem by offering part-timers higher pay with reduced benefits, according to Elaine Hunter, the bank's personnel officer.

Hunter told BNA that "the response [to the pay-without-benefits scheme] has been tremendous." The bank, which employs 150, began offering higher pay with reduced benefits in September in an effort to attract high-quality part-time workers. Within a two- to three-week period, Hunter said, the bank had 47 job applicants.

Hunter said that, in its standard compensation package for part-timers, the bank offers a salary of $4.72 an hour, which includes health insurance coverage at one-half the premium cost to the bank; vacation pay; holiday pay; up to five days a year of sick pay; two personal days off; eligibility for the retirement plan; and Saturday pay at time and one-half. Berkshire Savings also offers a benefit called career apparel: Employees who stay with the bank for two years are allowed to get $325 worth of work clothes — suits, dresses, skirts, and blazers — at no charge. Those leaving within one year, however, must return the clothing.

In September, the bank began to allow part-timers to elect a $7-an-hour salary, and — in return for the higher pay — to receive a career apparel benefit of $175, to be paid straight-time pay for Saturdays worked, and to be restricted to working no more than 1,000 hours a year.

Costs to Bank are Equal

Because "[w]e figured the $7-an-hour pay by adding up what all the other benefits are worth for a year's period," Hunter said, "in the end, we still pay the same. The cost of a regular part-time employee at $4.72 an hour and the premium part-time worker at $7 is actually equivalent."

Since the bank began offering the option in September, "all new part-time hires have gone for $7 an hour," Hunter observed. "The advantage to them is that they get summers off to be with their children, during which time the bank would hire college students."

Hunter added that "many of these part-time applicants had working spouses with adequate medical coverage."

Hunter said the bank also offered the option to full-time employees and existing part-time employees, but only two part-timers switched over to the higher pay.

Wage Survey

NAM FORESEES 5% WAGE INCREASES FOR INDUSTRIAL FIRMS IN 1986

Wage increases projected by U.S. industrial firms for 1986 will be about the same size — around 5.5 percent — as they were in 1985, according to a survey of more than 3,300 companies conducted by an affiliate of the National Association of Manufacturers.

Pay increases averaged 5.6 percent between August 1984 and 1985 for the firms covered by the survey, while the projected gain for next year is 5.5 percent.

About 1 million employees are represented in the survey, which was done by industrial relations group associations that are part of NAM's National Industrial Council. The council plans to conduct an annual survey, which will be expanded beyond the 15 states covered in this survey, according to Argyll Campbell, executive director of the council's Industrial Relations Group.

Projections for the 1985-1986 period show union production and service workers experiencing an average wage increase of 4.0 percent and non-union employees in that group being granted an average increase of 4.9 percent.

The NAM council's data indicated that pay adjustments for exempt supervisory, managerial and professional employees will average 5.6 percent for manufacturing firms and 5.9 percent for non-manufacturing firms over the year ended in August 1986, with the result being a weighted average of 5.7 percent for all firms.

For employees classified as executive officers, the projected pay increases for 1985-1986 averaged 5.9 percent for manufacturing firms, 6.2 percent for non-manufacturing, and a weighted average of 6.0 percent for all firms. These gains are down somewhat from average pay increases reported for the year ended in August 1985, the council reported.

Employee Benefits

DIFFERENTIATION IN PLANS SEEN AS WAVE OF THE FUTURE

Differentiation in employee benefit plans will become the "trend of the future," according to Charles W. Roers, director of compensation and benefits for PepsiCo, Inc.

Addressing the American Compensation Association's 30th national conference, held in Detroit, Rogers predicted a change in the current practice of providing benefits equally to all eligible employees.

At PepsiCo, benefit coverages already are differentiated for the restaurant, snack foods, and beverage employee groups, explained Rogers, who noted that plans vary in both level of coverage and availability.

BNA's EMPLOYEE RELATIONS WEEKLY

ROUTE TO

Volume 4, Number 1 THE BUREAU OF NATIONAL AFFAIRS, INC. January 6, 1986

HIGHLIGHTS

NOTE TO SUBSCRIBERS Two binders are supplied to *ERW* subscribers, each binder designed to hold six months of reports. The 1985 issues and indexes should be removed from the January-June binder; the index tab should be retained. Subsequent *ERW* issues now may be filed in the January-June binder. If you wish to retain the 1985 issues, you may purchase, for $10, a storage binder designed to accommodate one year of issues by writing to: BNA's Customer Service Department, 9435 Key West Ave., Rockville, Md. 20850.

LAST YEAR'S TOP 10 STORIES: This week's *Lead Report* provides rundown of *ERW*'s leading employment relations stories of 1985, among them, appointment of William Brock as Labor Secretary, Supreme Court's *Garcia* ruling, and demise of plant-closing legislation. (Page 3)

IMPACT OF TECHNOLOGY on workforce is shaped in part by management philosophy at particular work site, two former secretaries of labor tell National Governors' Association Conference. Director of George Washington University's Center for Social Policy Studies downplays impact of technology on workplace. (Page 29)

UNION SUCCESSORSHIP is not contract issue, and thus may never be resolved by arbitrator, rules federal appeals court, which says issue falls within NLRB's purview. (Page 21)

AIDS POSES UNIQUE PROBLEMS for health care employers, but also gives those employers unique opportunity to exercise leadership role in communities, American Academy of Hospital Attorneys is told at recent conference. (Page 15)

OFFER OF HIGHER PAY without benefits produced "tremendous" applicant response for part-time jobs at Berkshire County Savings Bank, Pittsfield, Mass., and solved bank's shortage of part-time employees, bank reports. (Page 13)

TAX EXCLUSIONS for employer-provided educational assistance and group legal service plan benefits expired Dec. 31, and face uncertain future in next session of Congress. (Page 23)

STATES HAVE SAME RIGHT as any consumer to choose with whom they will deal, and thus should be allowed not to deal with repeated violators of federal labor laws, Wisconsin assistant state attorney general tells Supreme Court in oral argument. (Page 27)

4 PERCENT GROWTH RATE in 1986 is predicted in revised economic forecast by President's Council of Economic Advisers. (Page 19)

'FRONT PAY' can be appropriate remedy under Title VII of 1964 Civil Rights Act, rules U.S. Court of Appeals for Sixth Circuit. (Page 17)

STEELWORKERS' BARGAINING GOALS for 1986 — job security tops list — are described by President Lynn Williams in address to IRRA meeting in New York City. (Page 25)

COMPARABLE WORTH: Washington Federation of State Employees and State of Washington announce settlement of union's "comparable worth" lawsuit. (Page 7)

GROCERY STRIKE/LOCKOUT in California ends as members of six United Food and Commercial Workers locals and numerous Teamsters locals ratify new contracts. (Page 7)

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APPENDIX - NFIB TESTIMONY
AUGUST 9, 1988
H.R. 4951

COMPARISON OF S.1265 ESTIMATES BY CBO AND IRET STUDY

	Premium Estimates		
	Single	Family	Average Employer Contribution
Gordon Trapnell in *Congress. Record*, 5/21/87	$808	$2,039	$1,186[1]
CBO, 6/5/87	$730	$1,835	n.a.
IRET study, 7/8/87	$1,200	$2,892	$1,600
Gordon Trapnell, 11/4/87	$891	$2,248	$1,308[2]
CBO, 11/4/87	$708	$1,798	$1,090[3]
Federal Govt., Blue Cross/ Blue Shield Low Option 1988 premiums	$1,300	$2,730	n.a.

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[1] The statement of Gordon Trapnell in the *Congressional Record* reports average employer contributions of $646 for an individual and $1,631 for a family. We have divided the average employer contribution by 0.8 (because S. 1265 requires the employer pay 80%) to obtain estimates of the premium amounts.

[2] In his testimony, Mr. Trapnell revised all his previous estimates upward by 10.25 percent because "many health insurers are now incorporating trend factors in the 16% to 20% range and raising premium rates by much larger amounts."

[3] The CBO average contribution per employer is 20 percent lower than the most recent estimate of Mr. Trapnell.

COMPARISON OF S.1265 ESTIMATES (continued)

	CBO	IRET
Costs for New Policies for Previously Uninsured	$25.1	$36.9
Employer Cost	21.8	29.5
Employee Cost	3.3	7.4
Unadjusted Employee Cost	5.5	-
Reduced non-employer insurance	-2.2	-

Increase the CBO premiums by 20% to bring them in line with the most recent estimate of Mr. Trapnell

	CBO	IRET
Costs for New Policies for Previously Uninsured	$31.9	$36.9
Employer Cost	27.3	29.5
Employee Cost	4.6	7.4
Unadjusted Employee Cost	6.8	-
Reduced non-employer insurance	-2.2	-

Increase the CBO premiums by another 15% to bring them in line with those in the IRET study

	CBO	IRET
Costs for New Policies for Previously Uninsured	$37.0	$36.9
Employer Cost	31.4	29.5
Employee Cost	5.6	7.4
Unadjusted Employee Cost	7.8	-
Reduced non-employer insurance	-2.2	-

COMPARISON OF S.1265 ESTIMATES (continued)

Expansion of Existing Employer-based Coverage[4]	$2.0	$16.3
Mandatory Duplication of Coverage	0[5]	$45.0[6]
Additional Administrative Costs	0	$2.0

Fiscal Associates, Inc.
November 19, 1987

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[4] CBO asserts that all existing employer-based plans in the United States will meet the Kennedy minimum package with the possible exception of pre-natal and well-baby care. Survey data, however, indicate that the average deductible in 1988 would be above the Kennedy minimum (about $262), implying that one-half existing employer plans would not meet the deductible. For the CBO estimates to be correct, plans with coverage superior to the minimum would have to be reduced to offset the increased coverage for the plans with less. CBO also ignores the higher employer contributions for family coverage, which has tax implications.

[5] CBO assumes that coverage will overlap for 13 million workers due to the requirement that each worker has his or her own policy through their employer. They assume that, because the added cost of these new policies would be approximiately offset by reduction in the benefits paid out under family policies, there would be no cost to his provision.

[6] Our estimate is based not on the benefits paid, but on the premiums that insurance companies would initially charge. Because there is insufficient information to identify the reductions in benefit payments due to the newly defined policies, insurance companies would tend to charge premiums based on the old patterns. This would, in the short run, result in higher premiums for both single and family coverage.

Chairman **Stark**. Thank you.
Mr. Dunbar.

STATEMENT OF RONALD H. DUNBAR, EXECUTIVE VICE PRESIDENT, HUMAN RESOURCES, RYDER SYSTEM, INC., MIAMI, FL ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS (NAM), ACCOMPANIED BY SHARON CANTER, VICE PRESIDENT OF INDUSTRIAL RELATIONS, NAM

Mr. **Dunbar**. Thank you.

My name is Ron Dunbar. I am the executive vice president of human resources for Ryder System, Inc. Ryder is a $5 billion service management company specializing in highway transportation, aviation and insurance management services. Ryder employs almost 60,000 people domestically and internationally.

Accompanying me is Sharon Canter, vice president of industrial relations for the National Association of Manufacturers.

I am speaking today on behalf of the National Association of Manufacturers. Mr. Chairman, I ask that you include my full written text as testimony for the record.

Both Ryder and the association are very concerned about the problem of uninsured workers in the United States and proposed legislation to mandate employer provided health coverage.

In 1987, corporations spent $155 billion to insure the medical well-being of workers and their dependents. These costs tripled since 1979, and health care cost increases show little or no signs of abating.

Major insurance companies are trending 1988 health care cost increases at 20 to 25 percent. Despite these enormous costs, private industry has done a commendable job.

Ninety seven percent of full-time workers employed by companies with 250 or more employees are covered by employer provided health plans.

Even so, Congress is faced with a dilemma. On one hand, there are at least 30 million Americans lacking health care coverage; on the other hand, the Federal deficit virtually precludes new Government spending initiatives.

Legislation transferring social costs to private industry is a seductive alternative which may do much harm to the American economy.

Mr. Chairman, you are to be commended for expanding the policy debate on improving access to health care for the uninsured. While we have some concern with various parts of the legislation, we believe your proposal raises some important issues—and challenges the private sector to develop approaches to address these concerns.

After reviewing the legislation we believe that H.R. 4951, while well-intended, would result in lost jobs, increased inflation and a reduced ability to compete in the global marketplace. It would also result in an inability to control costs and tailor our benefit programs to meet the needs of the people who staff our offices, shops and factories.

Provisions mandating maximum employee contributions, eligibility requirements, onerous penalties for noncompliance and other provisions of the bill do not take into account various business and employee needs.

At Ryder, we administer 34 plans just to meet the diverse needs of our workforce. In our view, it would be especially unwise to impose one national model on the diversity of businesses that exist in America today.

This would be like mandating one type of automobile for all Americans.

Politically, Medicare benefits as required by H.R. 4951 have become a yearly agenda item for Congress resulting in frequent changes. These changes would require costly administration amendments to employer plans and create increased communication complexities.

We are concerned about the implications this bill has for employer cost containment efforts. Many changes in medical practice such as outpatient surgery and utilization review have come about as a result of corporations who demanded cost containment.

These cost-containment initiatives would have been much more difficult to implement had we needed Government approval to modify a national health care plan.

The amount of money available for employee benefits is limited. We are concerned that mandating certain benefits, and, therefore, additional costs, will constrict an employer's ability to offer other benefits.

Benefits such as prescription drug coverage and assistance for drug and alcohol rehabilitation may have to be eliminated. These types of programs have substantially improved the quality of life for millions of Americans.

In an effort to further reduce costs, companies may elect to adopt the deductibles associated with the proposed legislation. These deductibles are substantially higher than is common in most benefit plans and will further deter people from seeking early care for medical problems, which is a primary goal of the proposed legislation.

Even worse, the substantial cost increases associated with mandated benefits may cause many small and marginal companies to go out of business, cut staff or reduce the number of part-time employees. This is particularly disturbing given that a recent study commissioned by the Department of Labor, Workforce 2000, suggests an increased need for flexibility and part-time workers to ensure America's competitiveness in the future.

We must remain competitive in our markets to ensure that the American economy remains strong and continues to create jobs for our people. Mandating employer provided benefits at the expense of jobs will swell the welfare roles and do little to resolve the issue of access to care.

Finally this legislation will decrease general tax revenues by allowing employers to take more tax deductions as a result of increase benefit costs.

We believe the solution to the health care access problem lies not in mandates, but in restructuring public programs and encouraging private initiatives.

In the private sector: We support the use of demonstration grants to provide cost-effective health insurance for small firms.

Examples of this include those sponsored by the Robert Wood Johnson Foundation.

We believe small firms working together are also demonstrating the advantages of group purchasing of insurance. Replicating these and similar efforts can do much to encourage affordable coverage without impairing employment, and America's ability to compete.

We also support making available low-cost catastrophic plans for small employers who have difficulty affording higher cost health plans.

In the public sector, on the Federal level: We believe Medicaid should be returned to the role it was designed to serve. And minimum Federal standards for Medicaid eligibility should be established.

To finance this, we recommend a shared Medicaid buy-in arrangement to assist low paid workers. The employee share could be scaled to income with a full Medicaid phase out at certain established levels.

This could also be financed through tax credits similar to those proposed in H.R. 4951.

To keep health care coverage affordable, we recommend that ERISA requirements preempt all state benefit mandates for health care.

And we support and commend this legislation for proposing 100 percent tax deductibility for self-employed persons.

Additionally we recommend this subcommittee look into providing tax incentives to hospitals and other health care providers who service a large number of uninsured persons. Proper incentives for providers could substantially reduce the problem of access to health care for the uninsured.

On the State level: Some 34 States operate indigent care programs targeted at such groups as young children and pregnant mothers.

Eleven states operate risk pools to assist the medically uninsurable and indigents purchase insurance.

To assist the medically uninsurable, we encourage States to establish pooling arrangements and set reasonable premiums.

In effect, both Federal and State Governments must explore creative solutions and continue to encourage private based initiatives to provide cost-effective health coverage.

In conclusion, the problem of providing access to health care for uninsured workers and their dependents is a serious social issue demanding the attention of this subcommittee and all segments of society.

We do not, however, believe that it is either necessary or desirable to tinker with an efficient system of employer-provided insurance which is working well for 137 million Americans.

H.R. 4951 may meet the short-term goal of access to care, but long-term it will result in the loss of jobs; reduced competitiveness of American industry due to the increased cost of goods and services; an escalation in the cost of already expensive health care; limitations on employee choice of benefits; and complex Federal regulations.

The National Association of Manufacturers pledges its cooperation to work with the subcommittee in seeking solutions on access to health care for uninsured workers.

We thank you for this opportunity to include our views in the record.

[The statement of Mr. Dunbar follows:]

Testimony of
Ronald H. Dunbar
Executive Vice President of Human Resources
Ryder System, Inc.
On Behalf of
The National Association of Manufacturers
On
Access to Health Care for Uninsured Workers
Before the
Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives
August 9, 1988

Mr. Chairman, and members of the Subcommittee, I am Ronald Dunbar, Executive Vice President of Human Resources, Ryder System, Inc., Miami, Florida. Ryder System is a $5 billion service management company specializing in highway transportation, aviation and insurance management services. We employ almost 60,000 people both domestically and internationally. Today I am appearing on behalf of the National Association of Manufacturers. Accompanying me is Joe Charles, Group Director of Employee Benefits, Ryder System Inc.

We are pleased to have this opportunity to submit testimony on the subject of access to health care for uninsured workers, an issue of great concern to the NAM and Ryder System, Inc. We agree with some legislators who have observed that those employers not protecting their employees raise costs for the rest of us. However, we contend that this represents only a portion of the cost shifted to employers. Medicare and Medicaid cost shifting, the medical malpractice delimma, the indigent problem, and high hospital vacancy rates all result in increased costs to employers. Mandates are not the solution to the issue of access to care. Instead, mandates which are overly specific and inflexible may have results harmful to both the national economy and those workers already protected by employer health care plans.

EMPLOYMENT AND HEALTH INSURANCE COVERAGE

The majority of Americans obtain health insurance through employer-based plans. In 1987, corporations spent over $155 billion to insure 137 million persons. These costs more than tripled between 1979 and 1987.

Despite these enormous costs, 97 percent of full-time workers employed by companies with 250 or more employees are covered by an employer-sponsored health care plan and over 65 percent of all workers are covered by such plans. Surveys show that the number of companies offering health care coverage continues to increase.

EMPLOYEE HEALTH BENEFIT IMPROVEMENT ACT OF 1988 (H.R. 4951)

Mr. Chairman, you are to be commended for expanding the policy debate on improving access to health care for the uninsured. While we have concern with various parts of the legislation, we believe your proposal raises some important issues, and challenges the private sector to develop approaches to deal with this complex health and economic problem. Below we comment on the proposal and offer some alternative solutions, we believe, are better suited to this nation's voluntary health care system that is successfully meeting the diverse employment and individual needs of America's workers.

POTENTIAL IMPACT OF H.R. 4951

H.R. 4951 would require all employers to provide health benefits to employees and their dependents. We believe that this legislation, while well-intentioned, would be harmful to the national economy and to individual Americans, in that it would result in lost jobs. It would also diminish our ability to tailor benefits programs to the needs and priorities of the men and women who staff our offices, shops and factories.

The Congress is faced with a dilemma. On the one hand there are at least 30 million Americans lacking a basic level of health protection; on the other hand a large federal deficit virtually precludes new spending initiatives. Legislation transferring social costs to private industry is a seductive alternative which allegedly appears to do much good and little harm.

This might be true if mandated benefits were nothing more than a hidden tax on the American people, and another cost of doing business to be added to the price of our goods. The realities are different. We do business in a global economy and many employers are at the limits of their ability to raise prices. If we raise manufacturing costs by mandating benefits, we will diminish American competitive strength in the global marketplace.

Benefit Design. H.R. 4951 calls for benefits similar in amount, duration, and scope to Medicare with certain exceptions. Use of this benefit package raises numerous problems. By modifying Medicare to include a $1,000 deductible for the individual and $1,500 for the family, this legislation will not meet the intended purpose of providing access to care for the uninsured. High deductibles will deter rather than encourage the needy to seek care, one of the original intentions of H.R. 4951.

Politically, Medicare benefits have become a yearly agenda item for Congress resulting in frequent changes. These legislative changes would require costly administrative amendments to employer plans and increased communications complexities in explaining the yearly statutory changes to employees.

The increased cost of Medicare led Congress to enact diagnostic-related-groups (DRGs) to encourage provider efficiency. We commend you as a leader on that effort. You are urged to consider the application of DRGs or similar cost management techniques should specific programs for the uninsured be implemented. Private sector health insurance through innovative plan design has been somewhat successful in slowing the rise in health costs. It should be noted that many believe DRGs were so successful that they have significantly contributed to reduced access to health care because hospitals can no longer shift costs to provide so-called "free care."

Under this legislation, the Secretary of Health and Human Services (HHS) shall determine whether a group health plan meets the requirements of the bill. While not expressly stated, we would interpret this to mean that actuarial equivalents would be considered by the Department. Establishing those equivalents and examining the plans of all existing employers offering benefits would seem to be a monumental task for the government to undertake.

Benefits could not be subject to a pre-existing condition limitation under H.R. 4951. Proposed technical corrections to COBRA would make the COBRA employer responsible for the pre-existing condition period until the new employer plan takes affect. Thus this provision seems redundant.

With regard to COBRA. the proposed legislation adds another layer of cost burdens to that initially imposed by that statute in 1985. Employers are now required to provide continuation coverage to certain classes of beneficiaries for periods of 18-36 months. Benefits are employee paid plus two percent to cover administrative overhead. H.R. 4951 requires employer paid continuation coverage for 60 days following the employees' "involuntary termination". In addition to lay-off this could cover discharge from the job. Many companies provide some type of layoff benefits through collective bargaining agreements or through other company benefits practice. Mandating paid continuation coverage will exascerbate the many problems COBRA has raised to date.

Potential Costs of H.R. 4951. The Congressional Budget Office estimates the proposed legislation would cost employers .45 per hour per employee or $20.5 billion for those firms that do not currently provide health insurance. We believe these costs to be underestimated. The $20.5 billion does not include costs to employers who already provide employee and dependents with coverage. Also not included is the increased price of goods and services that will be needed to finance the new federal mandate.

If the $20.5 billion cost of H.R 4951 is compared to the $7.4 billion cost of uncompensated care provided by hospitals to the uninsured, it seems like a large price to pay. This $7.4 billion cost also includes indigents that are not employed. In effect, business would pay over $20 billion to resolve a $4 billion problem. It would be far more efficient to make payments or tax credits available to hospitals and other providers who serve large numbers of uninsured. My state of Florida levies a tax on hospital revenues and then rebates a certain amount to affected hospitals that provide care to uninsured persons.

Mandated Medicare benefits would increase health care cost inflation which exceeded 11% of GNP in 1987. Congress' concern with health cost inflation led to a requirement that the new catastrophic benefits (PL 100-360) be phased in over a three year period. This acknowledgement is an indication of concern and a private sector version of Medicare would surely require similar implementation measures.

H.R. 4951 would be costly to the U.S. Government. By limiting the amount employers can charge employees for coverage, this legislation will increase corporate tax deductions for benefits and thereby decrease federal tax revenues by a significant amount.

Maximum Employee Contributions. H.R. 4951 sets 20 percent of premium as the maximum employee contribution for both individual and family coverage. In many American industries it has long been common practice for the employee to pay between 30 and 100 percent of the cost of dependent coverage. This provision alone would result in substantially higher costs to American industry. Ultimately, these costs would be passed on to the consumer, contributing to the current inflationary trend. Additionally, as stated earlier, tax revenues would be decreased.

Eligibility Requirements. Coverage under H.R. 4951 generally must commence on the first day of the month following 30 days of employment. The U.S. Bureau of Labor Statistics in its 1985 survey of medium to large companies found that 22 percent of manufacturing companies provided coverage after the worker had completed three months on the job. Eligibility for health benefits varies across industries for many reasons, most predominantly the degree to which the industry is labor intensive and subject to high turnover in the early months of employment. In our view it is unwise to impose one national model on a diversity of businesses.

The eligibility requirement of H.R. 4951 will add millions per year to employer costs. Short eligible requirements would be difficult for many companies to administer due to normal delays in processing paperwork, payroll deductions and insurance premium payments. Additionally, this provision is somewhat redundant given that COBRA protects most employees from a gap in coverage.

H.R. 4951 includes any dependent child under 26 years of age. This requirement is far beyond the customary definition of dependent child.

Cost Containment and Employer Flexibility. In 1988, insurance companies are trending health costs of 20-25%. We are now in the midst of the greatest premium increases employers have seen in the history of health insurance. The situation is worsening in spite of our cost containment efforts. Corporate America has seen employer health costs more than triple from $51.3 billion in 1979 to $155 billion in 1987. Strategies for dealing with this inflationary trend include pre-certification for hospital admissions, second opinions for elective surgery, waiver of deductibles and co-payments for patients who have minor surgery performed as out-patients in lieu of hospital admission, and employee audits of hospital bills. Today, hernia corrections, cataract removals, tonsillectomies and many types of knee surgery, are routinely performed in surgical centers on an out-patient basis. A few years ago these procedures would have required expensive hospitalization. These changes in medical practice have come about largely at the insistence of corporate insurers who demanded cost containment. Congress needs to continue to encourage, rather than discourage, private industry's cost containment efforts.

H.R 4951 fails to address reasonable and customary limits for medical services provided. Also absent from this legislation is a lack of limits on the maximum payments an employer is liable for per covered individual. Does this mean we must provide unlimited health care to an employee? Would a single hospital bill bankrupt an employer? This is particularly distressing to companies like Ryder who are self-insured.

The amount of money available for employee benefits in labor intensive industries is finite. To the extent that certain benefits are mandated, an employer's ability to offer other benefits is circumscribed. While the Ryder plan would have to be amended in a number of costly ways to comply with H.R. 4951, our plan also contains numerous provisions such as prescription drug coverage, and employee assistance for alcohol and drug rehabilitation, which are not required by the legislation. These provisions have been added to our plan in response to the needs of our employees. To the extent that mandated benefits will increase costs and limit flexibility, companies like Ryder may no longer be able to afford these types of employee benefits. In an effort to contain costs, companies may cut these programs which have improved the quality of life for many Americans.

The proposed legislation sets the deductible at $1,000 per individual ($1500 per family). To contain costs, companies which have now lower deductibles, typically $100 or $200, may be motivated to implement the higher limit, thus increasing the problem of access to care for the needy.

Under the legislation no co-insurance or other limits are permitted. A basic cost management principle relies on some type of co-payment to discourage excess utilization. Policy research has repeatedly shown that certain levels of cost-sharing has not resulted in adverse health consequences while at the same time helped to control health costs. Ryder requires a stop loss of 10% of pay up to a maximum of $5,000. This type of cost sharing protects our people from catastro- phic financial losses and encourages them to be efficient consumers of health care. Additionally, we make available to our employees information on provider fees and qualifications. This enables them to make informed choices in selecting physicians and hospitals.

The prohibition under H.R. 4951 of the application of deductibles and co-payments to prenatal and well-baby care violates the most basic principles of cost-effective plan design and could increase the cost experience of virtually every health care plan in American industry. As a practical matter, it seems unwise to single out these benefits given the varied nature of households today.

Penalties. The penalty of $100 per day per employee proposed for non-compliance under this legislation is onerous and excessive, especially given the administrative burdens that were mentioned earlier. Many marginal businesses could potentially be bankrupted by this legislation. More practically, we question the capacity of the IRS to enforce the penalty given the broad universe affected.

Flexible Benefits. Now offered by 29 percent of the Fortune 1000 companies and many smaller companies, flexible benefits represent another area of concern. Because most such plans require employees to accept a minimal health benefit or demonstrate proof of coverage outside the plan, many flexible health plans would not meet the standards of H.R. 4951. Philosophically, these plans recognize that all workers are not the sole breadwinner of a family consisting of a spouse and two children. A young single healthy employee may wish to accept a $1,500 health care deductible in exchange for increased vacation time. H.R. 4951 mandates a $1000 ($1500 per family) maximum deductible. Flexible benefits have become an increasingly popular tool for meeting diverse needs of the changing workforce and for attracting and retaining employees.

Overall Effect on Group Medical Plans. What would be the inflationary impact of a federal mandate on employer plans? This question was subject of an earlier survey on the Kennedy/Waxman bill (S. 1265/H.R 2508) which proposes a similar employer mandate. Group medical plan expenditures, according to Business Insurance magazine (9/7/87), could increase 24 to 70 percent, relative to the employer's contributions for dependent coverage. For example, a company now contributing 90 percent for employees and 25 percent for dependents could expect a 55 percent increase in costs. Cost increases would vary according to employer contributions for workers and dependents.

A survey (9/87) regarding S. 1265/H.R. 2508 of 70 companies conducted by Towers, Perrin, Forster and Crosby found that not one company met benefit requirements of the proposed legislation. These employer health plans failed to meet the proposed bill requirements for such reasons as lack of coverage for persons working 17 1/2 hours per week; exclusion for pre-existing conditions; and contributions for dependent coverage that exceeded 20 percent of premium. Thirty-five percent of respondents indicated they would stop hiring part-time workers or reduce part-time hours. This is particularly disturbing given that a recent study commissioned by the Department of Labor, Workforce 2000, suggests an increased need for flexibility and part-time workers to ensure America's competitiveness in the future.

Small Firms. For smaller companies with less generous plans, the cost would be proportionally greater. Their response to mandates may also be more dramatic. Increased costs for required benefits may cause some companies to cutback other benefits, reduce staff, or go out of business entirely. In fact, one not so small manufacturing company, Allison-Chambers, cited increased health care costs as a primary reason for filing Chapter 11. Though some small firms may not themselves trade overseas, they are often suppliers to large companies who do so. Mandates could prevent small firms from entering and competing in overseas markets altogether.

PUBLIC CONCERN FOR THE UNINSURED

The March 1987 Current Population Survey (CPS) conducted by the U.S. Census Bureau reported that in 1986, 83 percent of Americans under 65 were covered by health insurance. Three-quarters obtained coverage either through their own employment or that of another family member. The rest were covered through a mix of Medicaid, Medicare, Champus, private insurance or other sources. These numbers clearly show that the current health care system is working.

During 1986, an estimated 37 million persons had no coverage. More than half of this group were employed during at least part of the year. Younger and lower-paid employees, and those working part-time or for part of the year were most likely to lack coverage. For many healthy young workers, there is often little or no need for coverage.

We as concerned citizens and you as members of this Subcommittee may well ask why many employed persons are without health insurance. Many are low-wage workers employed by very small and often marginally viable firms. In fact, 61 percent of those firms with fewer than 25 employees do not offer health insurance.

One third of uninsured workers have incomes below the poverty level. Medicaid covers fewer than 40 percent of those persons living below the poverty line, and because 31 states require income of less than 50 percent of the poverty level for Medicaid eligibility, few working people, even if low-paid, can qualify. This can be easily corrected by modification in Medicaid eligibility requirements.

Cost-consciousness on the part of both government and the private sector has reduced the amount of uncompensated care that can be shifted to private-paying patients. Declining public health budgets have also had their impact and given large federal deficits Congress is reluctant to enact new public entitlement programs.

Another reason includes the use of part-time employees, variably defined as those working anywhere from 10 to 30 hours per week. Today, Ryder employs about 60,000 people, of whom almost 20,000 are part-timers, temporaries or casual workers. Our part-time workforce is composed of many retirees, students, and second wage earners who already have coverage under a parent's, spouse's, or prior employer's plan. In the last year we offered approximately 6,000 of our part-time school bus drivers the opportunity to purchase health coverage. Less than 300 people elected this coverage. The Pillsbury company had a similar experience. They offered their 30,000 part-time Steak and Ale employees the option of purchasing health insurance. Of them, 6,000 chose to purchase this coverage.

UNINSURED WORKERS: ALTERNATIVES FOR HEALTH INSURANCE COVERAGE

We believe that the solution to the problem of the working uninsured lies not in mandates which endanger both American jobs and the flexibility of the private insurance system, but in an approach involving the selected restructuring of public programs and the encouragement of initiatives already underway to put cost-effective private insurance within the reach of small employers. In this connection we would suggest the following areas for increased attention.

PRIVATE SECTOR ALTERNATIVES

NAM Initiatives. The NAM encourages its member companies to provide employee health coverage whenever and wherever it is practical to do so. We support the development of cost-effective group health insurance vehicles for small businesses and the use of managed systems for providing indigent health care. We also support tax incentives for the self-employed and for lower-income persons; and demonstration grants on cost-effective health insurance for small firms. The provision of H.R. 4951 to provide 100 percent deductibility for self-employed health insurance is a positive step that we hope can be enacted in the near future.

Basic Plans. For firms which are unable to afford more comprehensive protection, we believe basic low cost private sector catastrophic plans should be developed. For part-time workers, pro-rate premiums between employer and employee relative to the number of hours worked per week. To keep premiums reasonable, the plan design should be directed at meeting truly unbudgetable health care expenses, exclude dental, vision and hearing benefits, and provide an exemption from state benefit mandates.

Pilot Programs to Improve Access for Small Employers. The Robert Wood Johnson Foundation has funded fifteen grants to encourage the development of health insurance for small firms with particular emphasis on low wage earners. The Tennessee Association of Primary Health Care Centers (TAPHCC) designed a low-cost comprehensive health insurance plan, MedTrust, for uninsured workers of small firms in the Memphis area. When the employer and employee share proved insufficient to cover premium costs, TAPHCC sought the help of a 620 bed public hospital in Memphis that provided a high level of uncompensated care. The public hospital agreed to a discount on patient services. Physician services are provided through agreements with the Tennessee Primary Care Network. Thus, some innovative thinking and cooperation on the part of providers and employers in Memphis has led to improved access for a group of previously uncovered workers.

United Way of Bay Area. San Francisco is studying the feasibility of a health information brokering service to address the needs of small employers in obtaining health insurance coverage. An inventory of health plans serving small employers is expected to help such firms surmount this information barrier.

Replicating these and similar efforts can do much to encourage insurance coverage at minimual cost without impairing employment and America's ability to compete in the global marketplace.

Group Purchasing. Similarly, the Council on Smaller Enterprises, a division of the Greater Cleveland Growth Association, provides health insurance to over 4,500 small companies representing approximately 45,000 employees and with dependents serves some 100,000 persons providing administrative management for low cost health insurance. Of these companies, 75 percent have less than ten employees. The Council has been successful because it offers administrative efficiency, financial power, negotiating power, and greatly increased flexibility, all of which stem from the collective clout of working together.

PUBLIC SECTOR ALTERNATIVES

Medically Uninsurable. According to the Health Insurance Association of America, approximately one million persons are considered medically uninsurable, meaning that these individuals have been rejected or are significantly restricted in their ability to qualify for employer-sponsored or individually purchased insurance. To assist the medically uninsured, encourage states to establish pooling arrangements and set reasonable premiums with shortfalls financed through the use of general revenues. Plan design should provide basic coverage and include utilization controls to encourage cost-consciousness.

Medicaid. Less than 40 percent of the poor are covered by Medicaid, down from two-thirds a decade ago. Minimum federal standards for Medicaid eligibility, irrespective of family or employment status or place of residence are needed. Kentucky and Tennesee, for example, have eligibility levels at 35 percent and 25 percent of the poverty level for a family of four. To alleviate this problem, establish minimum federal standards for Medicaid at 100 percent of poverty to enable low-paid workers to continue in the labor force and decrease reliance on welfare; Medicaid should be returned to its original role in funding health care for low-income persons. Evolving solutions to finance long term care should in time decrease the burden on Medicaid now used to pay for much of this care.

Establish a Medicaid buy-in arrangement to provide low-paid workers access to health insurance. To control costs, consider development of basic coverage plans, utilization controls, managed care systems and other means to make care affordable. Develop shared financing arrangements for Medicaid. The employee share could be scaled to income with a full Medicaid phase-out at two times the poverty level.

Tax Incentives Initiatives. The income tax credit proposed by H.R. 4951 for self-employed and low-income persons represents an interesting financing mechanism and should be carefully studied. Its role in a Medicaid buy-in arrangement should also be explored. While the U.S. Treasury would lose revenue, there may be cost savings in other areas to offset that loss. We also believe that providing tax incentives to those persons who service the uninsured may be an effective solution to the problem. HMOs, PPOs and underutilized hospitals could provide the delivery system necessary if the proper incentive existed.

ERISA Preemption. Many states have passed statutes mandating specific benefit coverages. This has resulted in a maze of complex legislation that is administratively burdensome and at times at odds with widely accepted principles of cost containment. To enable the development of cost efficient health care plans by all firms, we recommend ERISA preemption of all state laws mandating benefits. H.R 4951 is to be commended for supporting this concept.

Risk Pools. H.R. 4951 calls for the establishment of state health insurance risk pools available to all persons residing in the state. Losses of the pool would be subsidized by an excise tax on all employers. The existence of a risk pool would surely discourage some employers from offering insurance and could encourage others to drop insurance. This would seem to fly in the face of the public policy goal of improving private sector health insurance coverage.

Currently, eleven states operate risk pools to help the medically uninsurable purchase insurance. No federal legislation was required. Pool losses are met through a variety of means including general revenues. Where appropriate, states should be encouraged to operate risk pools, determine premium costs, and develop mechanisms for covering pool losses.

Other State Actions. In addition to Medicaid, some 34 states operate indigent care programs targeted at such groups as young children and pregnant mothers. Others have levied taxes on hospital revenues and earmarked funds for those institutions serving high numbers of indigents. Through a variety of efforts, states are serving the uninsured and have done so without federal statutes. Because state efforts recognize local needs, they are in a better position to fashion responses targeted to the specific problem.

CONCLUSION

The problem of providing access to health care for uninsured workers and their dependents is a serious social issue demanding the attention of this Subcommittee and all segments of society. We do not, however, believe that it is either necessary or desirable to tinker with an efficient system of employer-provided insurance which is working very well for 137 million Americans, in order to provide access to health care for the minority who are uninsured. H.R. 4951 will not only fail to meet the short term goal of access to care, but long term it will result in complex federal regulations, increased costs to goods and services, the loss of jobs, diminished capacity to compete in global markets, limitations on employee choice of benefits, and an escalation of the cost of health care even beyond what can currently be projected.

The NAM pledges its cooperation to work with the Subcommittee in seeking solutions on access to health care for uninsured workers. We thank you for this opportunity to present our views before this hearing.

Chairman Stark. Mr. Dunbar, I would like to make some observations.

In the interest of letting my colleagues ask some questions, you might want to respond to these later.

In your testimony you say that the projected cost of $20 billion in H.R. 4951 would offset the roughly $7.5 billion of uncompensated care. I would like to point out that this is somewhat like apples and oranges.

You would have to add to that uncompensated care figure about $5 billion in savings to Medicare and Medicaid and the subsidies that are provided by various counties and States to these hospitals.

I would like to point out that I don't think it is a proper comparison because I don't think this is the cost we would be offsetting.

All of you have supported the tax credit for the self-employed. I don't know what that would cost because I have not received the cost estimate yet.

But it would seem to me that if the Treasury loses let's say, $1 billion by subsidizing the self-employed, ought we not to spend at least $1 billion on those self-employed employees? What is sauce for the goose here is sauce for the gander.

This is only a suggestion, but it is in effect what I am offering the small business operator for some of the inconvenience, the extra paperwork—understanding this will be an inconvenience. Please leave that in the bill as my bribe to get this small business order to do what is right, and not just pluck out the cherry here or chard there and go on.

The other thing is I don't think the NAM really wants to do what they say they are doing in their testimony. I suspect this idea of Federal standards for Medicaid at 100 percent of poverty would cost about $30 billion a year, half of which would come out of the Federal deficit and the other $15 billion to those States which have the low standards.

I have always supported Federal Medicaid standards. However, what we would do is bankrupt Mississippi, for example, and obviously we don't even want to talk about Puerto Rico.

It seems to me that it would be a lot cheaper to do H.R. 4951 than to raise $30 billion in Medicaid costs.

This really isn't the forum, but I hope you will rethink that.

Mr. Dunbar. We think the real issue is access to care.

Chairman Stark. I do, too.

Mr. Dunbar. Even in your opening comments you said the basic American right is access to care. If you think about access to care and tax incentives to promote the delivery system for the care of——

Chairman Stark. There are almost no profitmaking delivery systems. Less than 20 percent of the hospitals could benefit from any tax incentives. In fact, 80 percent or more are nonprofit hospitals.

Mr. Dunbar. Certainly the doctors' side of it is a tax incentive issue.

Chairman Stark. It might be.

Mr. Dunbar. I think if we not focus so much on insurance but focus on access and how do we provide access to care for people who otherwise don't have it, you come to different solutions than mandates. Mandates are very upsetting, I think, to business and industry because we have used the flexible spending accounts to provide tailored benefits programs for individuals and families.

What is a right benefit program for me may not be the right program for the person next to me. Most cost containment initiatives have come from private industry in incenting their employees to do different things that enable us to keep costs under control. When we have a mandate, we fear we lose that ability.

Chairman **Stark**. I recognize that. I am looking for a way to find a Massachusetts compromise on a Federal level.

Mr. Gradison?

Mr. **Gradison**. Thank you.

Mr. Rehr, listening to the previous panel, I had the understanding that small business and those who represent them in the State of Massachusetts were ultimately satisfied with the final package that was developed. What are you hearing from your members in Massachusetts?

Mr. **Rehr**. That is an incorrect observation. The Massachusetts NFIB opposed the Dukakis plan—members of the Massachusetts NFIB overwhelming oppose the Dukakis plan.

We will have to see, as you suggested, how it shakes out over the years.

Mr. **Gradison**. I have one other question which I would like to address to Mr. Young and Mr. Dunbar.

This basically asks you to put on your hat as an employer, that is the Ryder hat and, of course, the Hewlett-Packard hat. Isn't there a problem of free riders which reflects itself in cost shifting in the present system?

Don't, doesn't the employers who provide health insurance today, whether they like it or not, end up absorbing a portion of the cost of health care for the employees of companies that don't offer health insurance?

If that is a problem, should we be doing something about it?

Mr. **Young**. I have heard earlier that uncompensated care was a problem, and that got reflected in rates, and we needed to address that. Yes, I think that we have a problem where probably 5 to 10 percent of our hospital rates, or some meaningful number are inflated because of uncompensated care. I think that needs to be addressed.

I think one of the concerns I have is that in making more universal coverage, it doesn't necessarily follow that that will reduce our costs by less cost shifting. There is too much capacity in the health care system.

Right now in Santa Clara County, we have one doctor for every 300 people. We have significant excess of hospitals beds.

I think that I am concerned that in reducing a number of people without coverage and reducing the uncompensated care, you might drive hospitals to open chemical dependency units or other things. Even though we have an excess of doctors, the doctors' rates in our county are double what they are in some other metropolitan areas.

So we really need to look at that carefully as a country. Yes, it is there, and yes, we get short-term relief. But long-term, the bill would just create more capacity.

Chairman **Stark**. We are under the impression that poor people arrive at the hospital with more severe illnesses because they have not had the insurance to receive preventive care. Does that reinforce your concern?

In other words, what you are saying is that hospitals would lose business. They might lose even more business because of these people, and ostensibly we would be giving access to preventive care.

Therefore, you would have fewer severe cases coming into the hospital. That would also reinforce your concern?

Mr. **Young**. Yes.

Mr. **Dunbar**. It was said this morning very early that the service industry shifts costs to the manufacturing industry. From the standpoint of Ryder, I would like to make the point that we provide fully paid benefit programs with no cost shift that we know of to our customers. But I think cost shifting is present in every phase of our society.

I think you go into a retailer and you pay a cost shift for shoplifting and things like that. You are always going to have some form of cost shifting.

As my friend from Hewlett-Packard says, that is our problem to manage to that. We do manage to that by inciting our people to be as cost-effective as they can be. I would much sooner have some cost shifting in my rates than I would have a mandated benefit program. I think we all face cost shifting every day.

Mr. **Gradison**. I thank you all very much.

Chairman **Stark**. Mr. Donnelly.

Mr. **Donnelly**. Well, it seems as if you all go into some sort of varying stages of frenzy over the word "mandate." Let me just ask you this. Are you opposed to Congress mandating a minimum wage?

Mr. **Dunbar**. We have a minimum wage.

Mr. **Donnelly**. No, no. I know that. I mean are you opposed to mandating a minimum wage?

Mr. **Rehr**. Philosophically?

Mr. **Donnelly**. Yes.

Mr. **Rehr**. Sure.

Mr. **Young**. Sure.

Mr. **Dunbar**. I think the competitive force in the marketplace should——

Mr. **Donnelly**. You are opposed to it. Are you opposed to mandating workmen's compensation benefits?

Mr. **Rehr**. I would say our people would want a competitive system of worker's compensation.

Mr. **Donnelly**. No. Are you opposed to the law that mandates workmen's compensation benefits?

Mr. **Rehr**. I am not sure what our exact policy is. I could get back to you.

Mr. **Young**. I guess I would answer this way. We wouldn't be opposed to worker's protection. We would oppose too much limitation of our freedom to work with our employees to develop the right protections.

Mr. **Dunbar**. I favor motherhood.

I favor apple pie, and I am not sure about worker's compensation.

Mr. **Donnelly**. How about child labor laws?

Are you opposed to using children in forced labor without a minimum wage?

I am not being facetious. But, you know, I am trying to get where you are coming from. I think a better phrase than "mandate" would be provide your employees.

You all seem to agree that every man, woman and child in America deserves access to quality health care both for actual illnesses and preventive care.

Agreed?

Mr. **Rehr**. Yes.

Mr. **Donnelly**. The question is who pays. Isn't that fundamentally the questions?

You don't want to pay. You want somebody else to pay.

Mr. **Dunbar**. That it come from the public sector, through reallocation of——

Mr. **Donnelly**. Taking your argument, taking my friend, the Republican, argument, is that the public sector, the Government doesn't pay. The people pay, the corporations pay. I have been hearing that for 8 years.

How do we do it? Do any of your organizations favor an increase in the Social Security tax?

Mr. **Dunbar**. No, sir.

Mr. **Donnelly**. You don't. Do you?

Mr. **Rehr**. No, no. I wanted to ask you a question, though.

Mr. **Donnelly**. You are not allowed. You don't understand.

Mr. **Rehr**. Democracy.

Mr. **Donnelly**. That is right. That is how it works. First Tuesday of every November.

I mean isn't that the essence of the argument. We all agree that no child, no individual ought to be turned away from quality and access to quality health care.

The argument is how are we going to provide it. The first argument is how we provide it today. My supposition is that we are providing it for acute care.

I don't often read about very sick people being turned away, although you do from time to time. But they do get the care eventually some place after knocking on enough doors and somebody pays.

In the present system of reimbursing that cost, it is an inefficient system. Would you agree to that?

The system is basically based upon property taxes, payroll taxes. It is a very inefficient way to do it.

Now if we just are going to argue this debate on mandating that if you are going to go back to your members and say the people in Massachusetts or the Congress or the Democrats or whoever those awful people are out there are going to mandate, it would be fair for us in turn to say "Understand one thing about the people that oppose what we are trying to mandate. They were against mandating child labor laws. they are against mandating workmen compensation protection. They are against mandating wage protection."

I think it is something that realistically and reasonably we should look at as a nation. If one is going to get tied up in the verbiage of mandating this and the Government's role, the people that effectively lose are those millions of people.

I understand the myriad of problems. That is why I asked the Massachusetts question about how our economic competitors might be hurt because we are the one and only, and whether it was smart for us to go do it alone. I asked them that question.

I asked that question during the entire debate that took place in Massachusetts.

I also understand a revolving and changing workforce, a much more mobile workforce than was when universal coverage was first proposed, when Woodrow Wilson and Claude Pepper first put the bill in.

So, you know, I don't really have a lot of—that was more of a statement than a question. But the fundamental issue here is not over the rightness or wrongness over access.

The fundamental question is over who pays for that access and who pays for that quality because we have access. We just don't have quality.

Mr. **GRADISON**. I am repeating something I said before. I just want to say so you know where I am coming from.

I am not troubled by the notion of mandates. That is the role of the Government, is to decide what you mandate and what you don't.

What bothers me these days is that there is about half a dozen items on the national agenda, each of which is being argued for and sometimes by different groups as being absolutely essentaily we mandate, increase in the minimum wage, parental care, child care, of course we are also on the long-term issue.

If I add them up, I get worried about what impact on the economy may be. Yet, if I talk to people who are interested in mandate A, they may say, well, you know, what you say is very important. By God, we have got to do something about this problem of—and you fill in the blank.

So what I would wish we could try to sort out, and I think your state has sorted this out, and I give them a lot of credit for it, is what is the most important, and let's get started on that and not try to do everything all at once, which is where I sense where the political dialog is right now.

Mr. **DONNELLY**. I don't see any problem with addressing the major issues that affect serious concerns of the populace in America.

I don't think there is anybody here that objected when we mandated the lowest corporate tax rate in my lifetime under tax reform, or we just mandated the extension of the research and development tax credit. I think it is on which side of the bread you put the peanut butter and jelly.

I just would like to point out the difference from the perspective of mandate. You know, we mandate low tax rates, we mandate tax incentives for American corporations to be competitive, but we can't discuss a mandate about the access to quality health care for American people or a mandate that would provide adequate salaries or adequate workmen's compensation for our injured employees.

I guess that depends on which side of the Chairman that you sit.

Chairman **STARK**. Let me also admonish the advocates here of free enterprise. As purchasers, I don't believe that the average consumer shops for medical care. No one goes to the hospital for the fun of it.

When you have a free weekend, you don't sign into the hospital. If you live in Florida where the weather is nicer. You would rather live on the beach.

But we in this country, in the aggregate, are paying 11, 12 percent of our gross national product for medical care. There is no other industrialized nation in the world, many of whom have good quality medical care, that is paying much above 8.

The market—you guys fight with the AMA for a while. Don't let me have all the fun.

Mr. **Dunbar**. In Ryder we put in a program called Take Care. We told our employees the money they were spending was their money on medical care.

We told them we wanted them to spend it at reasonable levels. We had employees terminate dentists and doctors who charged greater than reasonable and customary.

We put a computer system in Miami where all the physicians in Dade County are listed based on their credentials and cost. Employees can access those physicians and hospitals by type of disease or illness.

When they need a physician or they need a hospital, they can determine the credentials, certifications and the cost. And it works.

Mr. **Donnelly**. Let's——

Mr. **Dunbar**. People do spend their money wisely when you ask them to do that. They understand the corporation cannot continue to throw dollar after dollar into medical programs.

We said we want to provide you with a reasonable benefit program. We can't do it unless you take responsibility, and they did.

Chairman **Stark**. I would really love to have all of you back. We are running over our time limit and must allow the Social Security Subcommittee to meet in this room. I do, however, appreciate your concerns.

I hope that you will go back and decide what you are going to offer me in exchange for full deductibility of insurance for the employer.

I thank the panel very much.

We appreciate your being here.

[Whereupon, at 1:50 p.m., the subcommittee adjourned.]

EMPLOYEE HEALTH BENEFITS IMPROVEMENT ACT OF 1988

THURSDAY, SEPTEMBER 22, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman **Stark**. The Subcommittee on Health will begin its hearing on H.R. 4951, the Employee Health Benefit Improvement Act of 1988.

The bill would require employees to provide health insurance to all full-time employees and their dependents.

Some have claimed that this proposal is socialized medicine. That is absolute nonsense.

How expanding private health insurance to every working American is socialized medicine is beyond me.

H.R. 4951 would merely assure that the 23 million hard-working Americans and their dependents who lack basic protection would receive the same private coverage that the 135 million covered under employment-based health insurance plans receive today.

Requiring employers to provide basic privately-sponsored health coverage to workers and their families is not a new idea. Nor is it one for which we on our side can claim authorship. It was first proposed by the Republican Administration as part of the Comprehensive Health Insurance Act first introduced in April 1971 and reintroduced in 1974.

Those who oppose requiring employers to provide basic health coverage also oppose publicly-financed responses to the problem. The only conclusion one can reach from this is that they favor leaving 37 million Americans permanently without basic health protection. This is simply unacceptable.

The goal of comprehensive health benefits for all is one that has eluded us since the Congress first took up the question of universal health insurance in 1918. It seems amazing to me that we continue to let hard-working Americans fall between the cracks.

Basic health insurance is a right of every American. Unfortunately, our society clearly has not yet reached that goal, and we appear to be slipping further away every year.

The rising level of interest means that we may finally make meaningful progress towards solving the problem of assuring basic health protection. I look forward to working hard together to achieve that worthy goal.

Our hearing today will focus on testimony from a number of distinguished economists discussing alternative approaches to comprehensive health insurance and the impact of such proposals on our economy. We will also hear further testimony defining the extent of the problem, and will conclude with perspectives from the health insurance industry.

Our witnesses will particularly address themselves to concerns which have been raised regarding the effect of this bill on employment generally and on the small employer in particular. I look forward to their testimony.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

I am delighted that you scheduled this hearing. It is timely and a very important subject. I am particularly glad that the focus will not be limited to the very serious and understandable concern that we have about absent health care coverage, but also will examine the economic impact of some of the alternatives which are being discussed.

It doesn't particularly serve the purpose if we do that in a way that kills the goose that laid the golden egg; that is, that our economy that makes it work has to do with jobs in large numbers over recent years.

So, Mr. Chairman, I join you in your concern about the issue, and look forward to hearing from the witnesses.

Chairman **Stark**. Thank you.

Our first witness is our colleague, the Honorable Don Pease, a member of the Committee on Ways and Means. You are welcome here this morning. Proceed in any manner in which you are comfortable.

STATEMENT OF HON. DON J. PEASE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. **Pease**. Thank you very much, Mr. Chairman and Mr. Gradison.

I would like to thank you for the opportunity to testify. Mr. Chairman, I applaud and share your deep commitment to finding a solution to the problem of the uninsured. Your bill, H.R. 4951, reflects your customary, thoughtful approach to public policy.

As I understand it, today's hearing is about both the bill and the underlying problem: The 38 million Americans without health insurance. For this reason, I would like to take a couple of minutes to call attention to my own proposal, which I have introduced as a bill in each of the past three Congresses.

My bill, H.R. 2696, would essentially create a series of risk pools, with at least one in each State, and more than that in a large State. The plans would be administered by the lowest bidding private insurer, which would be guaranteed 60 percent of the business in that area. Other carriers could participate, provided that they offered the same rates and conditions as the lowest bidder.

Beneficiaries would pay a premium of 6 percent of their family income and assets, subject to a reasonable exclusion for the primary residence and personal automobiles. One advantage of this plan is that it may shut off the comments you mentioned about socialized medicine. Any losses in the plan would be covered by a doubling of the Federal excise on cigarettes and general revenues.

This plan meets some of the objections of business groups to proposals that require them to foot most of the bill for expanded health insurance coverage. Small businesses raise the concern that they can ill afford additional costs in today's highly competitive economy. By not involving employers directly, my bill sidesteps this problem. In so doing, it avoids creating an incentive for employers to replace full-time with part-time employees or to suppress wage increases in order to mitigate new health insurance costs.

However, in meeting small businesses' objections, my bill would use taxpayer funds. In other words, it would spread the costs more broadly across society. By contrast, the chairman's bill would have little impact on the Federal budget deficit. This is no small consideration in view of the Federal Government's fiscal problems.

For their part, employer-based proposals tend to leave an important part of the problem unresolved. Roughly 40 percent of the uninsured are unemployed and self-employed people and their dependents, who are not poor enough to qualify for medicaid. I would like to see these people included in any legislative solution the subcommittee approves.

H.R. 4951 takes a step in the right direction by inducing States to establish risk pools. Nevertheless, the unemployed probably could not afford the coverage provided by these pools, which would have a premium of up to 150 percent of the average cost of a standard group policy.

Perhaps, Mr. Chairman, we ought to consider some combination of the two approaches to limit the cost to the Federal Treasury and small businesses, as well as to make health insurance affordable for all Americans, both employed and not employed.

I would like to suggest my approach as a possibility for discussion in this light and ask that you give it serious consideration. Thank you very much.

Chairman STARK. Thank you, Don.

Would your bill cover employed or only those unemployed who have no opportunity?

Mr. PEASE. Mr. Chairman, my bill would cover both groups. In fact, the premise of my bill is that anybody employed or unemployed, self-employed or otherwise, who is willing to spend 6 percent of his income and assets per year on a premium, could qualify for this coverage.

Chairman STARK. I think, as you will hear later today, that there are two or three plans. No one has any problem with recommending one. That is very easy. Everyone wonders who should pay for it. Whether you make every American pay something in a payroll tax or an income tax or through the church, I mean they are all beginning to focus on pretty much the same thing.

I think many people are thinking of having States administer programs. I suspect that would entail minimum Federal benefit, but that is a question of faith.

The issue that we have to get over politically, and then it seems to me, it is where we can find a compromise on how to spread the cost, is: Are we going to start and accept as a premise that every American will have a source of paying for medical services and will not have to stand in line in an emergency room? If you start there, then I think your bill will be considered, along with one or two other programs; and during the course of a couple of years' debate, I think we will use several.

I think we all have to get together to get enough support to see that this will start. Then I think the best prospects for helping is trying to find the fairest way to do that. I look forward to working with you and to your input regarding these problems as we get closer to our goal.

Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

Don, I really appreciate your testimony. I think you have opened up an avenue which has been overlooked in a lot of discussion, which is how to do this without putting the whole burden on the employer.

I sometimes wonder whether we can involve the employers by requiring an offer of group health, but not necessarily requiring that they pay for it or not pay for all of it, because the group policy itself is a tremendous advantage to the individual as far as access and price.

You mentioned a financing mechanism that you had in mind. I have just one question. Have you any revenue estimates or cost estimates as yet with regard to this plan, the general revenue aspect of it?

Mr. PEASE. Yes, Mr. Gradison, we do. In addition, the revenue would be brought in by increasing the cigarette tax. CBO estimates that the plan would cost $5 to $13 billion a year. Obviously, this is another threshold that we have to get over. We must decide as a society and a Congress that we are willing to and able to commit general fund revenues for solving the problem of uninsured people.

Mr. GRADISON. This is a second question. I am just curious about it. Do you know whether the estimates take into account those who lack health insurance in their own names, but are covered by somebody else in the family?

I appreciate that there is a problem out there. I am not trying to minimize it by asking the question, but I have had trouble getting data with regard to how many of that 37 or 38 million really have health insurance, although it is not in their own name.

Mr. PEASE. I don't know what is behind the CBO's estimates.

Mr. GRADISON. Perhaps they took that into account in making their estimates.

Mr. PEASE. You make a point. I always assumed when the figures of 37 to 38 million are quoted that they refer to people who neither have their own policies nor are insured through someone else. I think this would be a very important question for this committee to answer before we proceed too much further.

Mr. GRADISON. I am advised that they are supposed to be checking out the numbers, in order to bring the numbers down.

Mr. PEASE. Pardon me, did you say that some of the 37 or 38 million may have been covered in somebody else's policy? Oh, somebody advises me here that they don't have the figures.

Mr. **Gradison**. I am advised that a fairly recent survey attempted to estimate this, and will reduce the numbers from 37 to 34 million or thereabouts.

Mr. **Pease**. We are still talking about a lot of people. For the record, I would like to clarify a statement I made earlier about the CBO cost-estimate being from $5 to $13 billion. The $5 billion is an estimate for a low option health insurance policy; $13 billion would be for a relatively high-option policy.

Mr. **Gradison**. These are basically family packages, not major medical packages.

Mr. **Pease**. Yes, a basic health insurance package.

Mr. **Gradison**. You certainly have helped the subcommittee. We appreciate your taking the time to be here. The subcommittee will temporarily be in recess until the chairman returns from the vote. Then we will move ahead with the panel of Ms. Davis and Dr. Reinhardt.

[Recess.]

Chairman **Stark**. Our next two witnesses appear as a panel. They are Dr. Karen Davis, Ph.D., chairperson and professor, Department of Health Policy and Management, School of Hygiene and Public Health, the Johns Hopkins University, Baltimore, Maryland; and Dr. Uwe Reinhardt, Ph.D., James Madison professor of political economy, Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, New Jersey.

We are honored to have you both here today. Your comments and studies are noticed by all of the people in the health care field. I would like to ask both of you to proceed. We have your prepared testimony. I would like to have you proceed in whatever manner you are comfortable with.

Dr. Davis?

STATEMENT OF KAREN DAVIS, PH.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Ms. **Davis**. Thank you, Mr. Chairman, for this opportunity to testify on the need to improve health insurance coverage in the United States. I would like to highlight today some of the problems people without health insurance face, and to suggest ways for closing the gap.

As the cost of health care has risen sharply over the last decade, every family in the United States needs health insurance to avoid the financial catastrophe that a serious illness or injury can bring.

About 37 million uninsured Americans every day face this risk. Two-thirds of these Americans are employed, most at modest wages that are insufficient to protect the family should a serious illness strike. The other third are even less fortunate: Poor or near-poor families who do not qualify for Medicaid because of serious restrictions on who can be covered, the unemployed, and older adults between the ages of 55 and 64 including widows and retired workers and their spouses who do not yet qualify for medicare.

The absence of health insurance for these groups is not only a serious financial matter but poses a significant barrier to needed medical care and undermines both the health and economic security of families.

Particularly alarming is the fact that access to health care in this Nation is becoming worse, not better, and the ranks of the uninsured are swelling.

Today, I would like to share with the committee the latest data on health care costs that face those without health insurance, gaps in health insurance coverage, what we know about the consequences of these gaps in coverage, and suggest ways in which gaps in health insurance coverage could be closed.

Health care costs and the uninsured:

Health care costs have risen rapidly in the 1980's. National health expenditures doubled between 1980 and 1987, from $250 billion in 1980 to $500 billion in 1987. In 1980, the average per capita health expenditure was a little over $1,000. By 1987, on average each man, woman and child incurred health expenses of almost $2,000.

If current policies remain unchanged, this will increase further to $2,500 in 1990. As a percent of the Gross National Product, health expenditures have increased from 9.1 percent in 1980 to 11.2 percent in 1987, a 2-percentage-point increase in only 7 years. This is projected to increase to 12 percent in 1990, and will reach 15 percent by the year 2000 if nothing is done.

These figures are truly astounding, but their impact on those Americans without any health insurance coverage is devastating. If a patient is hospitalized today, the average cost of a hospital stay is over $3,900, compared with $1,800 in 1980. Physician fees have increased 8 percent a year in the 1980's, 3 percentage points faster than the Consumer Price Index.

The Medicare premium has increased from just over $115 a year in 1980 to about $300 today. The Medicare hospital deductible has increased three-fold from 1980 to 1988, up from $180 in 1980 to $540 today.

Fortunately, the elderly are protected from the most serious brunt of medical expenses by Medicare. The recent passage of the Medicare Catastrophic Coverage Act of 1988 will further enhance financial protection against serious illness for Medicare's elderly and disabled beneficiaries.

However, about 35 million Americans have no insurance from private companies or public programs to shield them should medical catastrophe strike. Particularly disturbing is the fact that the ranks of the uninsured are growing.

For these Americans, a single hospital stay can wipe out a lifetime of savings and saddle the family with debt for years to come. No other nation in the industrialized world subjects its families to such a prospect.

Health insurance coverage in the United States:

People under age 65 obtain health insurance coverage in three major ways: They receive group health insurance provided by their employer; they purchase health insurance individually from private health insurance companies; or they qualify for coverage under the Medicaid program.

Coverage under an employer health plan is the most common way in which the nonelderly obtain health insurance coverage.

About 132 million nonelderly people, or about two-thirds of the nonelderly, have employer-provided health insurance coverage. About 24 million are covered by Medicaid or other public programs. About 16 million purchase private health insurance coverage individually, leaving an estimated 35 to 37 million uninsured.

The common impression is that the uninsured are outside the work force, mostly young adults who have not yet found jobs. This is not the case. Surprisingly, over half of the uninsured, 19.6 million people, are in families where at least one member has a full-time job working 35 or more hours per week. Two-thirds of the uninsured are in families where at least one member works at least 17.5 or more hours per week.

About one-third of the uninsured are children under age 18. Half of the uninsured are parents or other adults between the ages of 17 and 45. The remaining 16 percent of the uninsured are split equally between older adults between the ages of 45 and 54 and between the ages of 55 and 64. Many of these older adults are widows or spouses of retired persons who do not yet qualify for Medicare.

Nearly all of the uninsured have modest incomes. About one-third have incomes below the poverty level. Only 20 percent have incomes greater than three times the poverty level. Individual purchase of private health insurance is not economically feasible for most of the uninsured. Individual plans typically have inadequate benefits and charge premiums well in excess of actual benefit outlays.

Medicaid fails to cover the majority of the poor. Absence of Medicaid coverage among the poor occurs because States set income eligibility levels well below the Federal poverty level and because categorical restrictions limit coverage largely to one-parent families, excluding two-parent poor families, childless couples and single individuals.

The majority of workers receive health insurance coverage from their employers. However, 22 million Americans in families where one person works at least half-time fail to receive coverage. Gaps in employer-provided health insurance coverage occur because such coverage is optional for employers.

About half of all employed uninsured persons work in firms with fewer than 25 employees. Employer-provided health insurance coverage is particularly low in certain industries, including agriculture, construction, retail trade, and services. Coverage of workers is lower in the South and West than in the North and Central regions of the country.

To a considerable extent, health insurance coverage in this country is a matter of luck. Those fortunate enough to be employed by large, unionized manufacturing firms are also likely to be fortunate enough to have good health insurance coverage.

Those who have modest incomes, live in the South and West or in rural areas, and those who are black or minority group members, are more likely to bear the personal and economic effects of lack of insurance and the consequent financial barriers to health care.

Health insurance coverage has been getting worse, not better. Several factors are responsible for this:

The growth of jobs in the service sector which tend not to have health insurance coverage.

The growth of jobs in smaller firms.

The increasing tendency for employers to require employee contributions to health insurance premiums, including paying the full cost of dependent coverage.

The growth in one-parent families, which are less likely to have health insurance coverage than two-worker families.

The growth in the number of adults between the ages of 17 and 45 which are less likely to have health insurance coverage.

While considerable further analysis and research will be required to sort out the independent contribution of these and other factors, it is clear that gaps in employer-provided health insurance are responsible for a large portion of the uninsured population.

The uninsured and access to health care:

A new report on access to health care in 1986, recently released by the Robert Wood Johnson Foundation, contains evidence on the deterioration in access to health care in the 1980's. Thirteen and one-half million people reported not receiving medical care for financial reasons. An estimated 1 million individuals actually tried to obtain needed care but were turned away. Several indicators suggest that progress in improving access to health care for the poor and minorities has been reversed between 1982 and 1986.

The Robert Wood Johnson Foundation access survey found particular problems for the uninsured. The uninsured are one-third more likely to be in fair or poor health than the non-elderly insured. Yet, despite their poorer health status, the uninsured receive 27 percent fewer physician services and are hospitalized 19 percent less frequently than the insured.

One-fifth of the uninsured with chronic illness did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms, for example, bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet, did not see or contact a physician.

One-fifth of the uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in the year.

Clearly, absence of health insurance coverage is not only a serious financial problem, it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

Alternative approaches to closing the gaps in health insurance coverage:

It is urgent that action be taken to provide at least some minimum health insurance coverage for all Americans. In evaluating the economic impact of any one approach to dealing with this problem, it is important to consider the alternatives.

The major approaches which could be followed to close the gaps in health insurance coverage include:

Expanding public programs such as Medicaid or Medicare to cover the uninsured or establishing a new public program; subsidizing the purchase of individual private health insurance through Federal or State government funds; taxing hospitals or private health insurance plans to create a pool for paying for care for the uninsured; or requiring employers to provide health insurance coverage for employees and dependents.

I would like to comment on each of these four approaches. The first, which would require substantial new taxes to cover all of the uninsured under a new program, would be very difficult, given budgetary problems.

In addition, the second approach of subsidizing the purchase of individual health insurance would use additional taxes to pay for subsidies of an inherently inefficient type of health insurance coverage. Individual health insurance plans run administrative costs 30 to 50 percent of benefits, compared to 3 to 5 percent administrative costs for Medicare and Medicaid.

Public monies would go further by directly covering the uninsured under Medicaid or Medicare than by indirectly subsidizing coverage under individual private health insurance plans.

The third approach of taxing hospitals or private health insurance plans would shift the financial burden of covering the uninsured onto the insured. Those employers providing coverage for their workers would be doubly burdened: Picking up the costs of their own workers plus the cost of workers in firms not providing such coverage.

In the light of these alternatives, requiring minimum employee health insurance coverage has much to commend it. It would minimize new taxes required to fill the gaps in health insurance coverage. It would build on the current system of employer-provided private group health insurance. It would spread the cost of expanded coverage more equitably among firms, rather than concentrating the burden on those firms voluntarily electing to provide coverage to their workers. It would permit limited public funds to be targeted onto low-income individuals not covered by employer plans.

Minimum employer health insurance coverage:

The Employee Health Benefit Improvement Act of 1988, introduced by Chairman Stark, represents an important step toward assuring better health insurance coverage to all workers and their dependents who work at least 17.5 hours per week, with special provisions for coverage of farm workers.

Importantly, no employer plan could exclude a worker or coverage for specific health problems because that worker or dependent already had a health condition.

Employers would contribute at least 80 percent of the premium for both workers and their dependents. Low-income employees would receive some assistance in meeting their share of the premium through a health insurance income tax credit, similar to the existing earned income tax credit.

Under the plan, all working families would be protected from catastrophic health care expenses through a ceiling on out-of-pocket health expenses not to exceed $1,500 per family, or $1,000 per individual. In addition, the bill would help get all children of working families off to a healthy start in life through comprehensive coverage of maternal and infant health care.

The primary criticism raised against such a proposal is that it would be an economic burden on low-wage firms and might result in loss of jobs for low-wage workers. There is some evidence that suggests a 10-percent increase in labor costs might result in a one-half to 1-percent decline in employment. Applying this to the low-wage uninsured suggests a potential employment loss of under 50,000. However, this job loss would be more than offset by additional jobs of 100,000 or more in the health sector to provide new services.

There is reason to believe that even these modest adverse employment effects are overstated. First, the plan outlined does not constitute an excessively burdensome plan. Second, the labor market for entry-level workers is tightening with the drop in fertility in the mid-1960's leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely.

Third, the minimum wage has not been increased since 1981, so that the cost of entry-level workers has declined in real terms over the last 6 years. Fourth, the types of jobs that are potentially affected are largely in the service sector or retail trade, which are not as sensitive to international competition.

Another concern is that small firms would not be able to purchase health insurance economically. The option of purchasing coverage through State pools would assure even the smallest firms of the availability of coverage. Consideration might be given to holding premiums in the State pool to no more than 20 percent above the average premium in the State.

Medicaid coverage:

Requiring employers to provide coverage for their workers and dependents would add 22 million more people to health insurance coverage, and drop the number of uninsured to less than 15 million. Most of the remaining uninsured are poor or near-poor. While State pools might be of some assistance to the 5 million with incomes above twice the poverty level, most of these individuals will remain uncovered.

Another step that needs to be considered is expansion of Medicaid coverage to cover all poor uninsured, as well as permitting the near-poor to purchase Medicaid on a sliding scale basis.

Under this proposal, the Medicaid program would be expanded to provide acute health care benefits to the entire population falling outside employer-mandated coverage and Medicare coverage. It would provide complete coverage to all poor, and premium-financed coverage to others. Medicaid would be a secondary payer for individuals covered under employer plans or medicare.

The provisions of this component include:

Automatic coverage of all individuals under the poverty level; optional purchase of Medicaid to all nonpoor not covered under an employer plan on a sliding scale premium basis; the Medicaid program would cover the current mandatory benefits plus prescription drugs, without arbitrary limits on amount, duration or scope of benefits. For individuals purchasing coverage with a sliding-scale premium, modest cost-sharing provisions could be included.

I would think you would look at the statewide pools and consider lowering those premiums to maybe not more than 20 percent. I understand the jurisdiction of the program rests with the Energy and Commerce Committee, but I think that is a feasible approach that ought to be considered for covering the 10 million poor and near-poor uninsured who would not be covered with this proposal.

I would recommend expanding that to cover all the poor uninsured, as well as expanding coverage for the near-poor. This public-private partnership set forth here is an economically and administratively feasible approach to remedying the gaps in health insurance coverage that threaten the health and well-being of a significant portion of our Nation's population.

While the specific details could be modified, or even more modest steps taken incrementally to close these gaps in coverage, the plan proposed here should be carefully considered and debated. I congratulate the committee for undertaking serious examination of ways in which such gaps in coverage can be eliminated.

Thank you.

Chairman STARK. Thank you.

[The statement of Ms. Davis follows:]

TOWARD BETTER HEALTH INSURANCE COVERAGE

Karen Davis
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Thank you, Mr. Chairman, for this opportunity to testify on the need to improve health insurance coverage in the United States. As the cost of health care has risen sharply over the last decade, every family in the U.S. needs health insurance to avoid the financial catastrophe that a serious illness or injury can bring. About 35 million uninsured Americans every day face this risk. Two-thirds of these Americans are employed, most at modest wages that are insufficient to protect the family should a serious illness strike. The other third are even less fortunate -- poor or near-poor families who do not qualify for Medicaid because of serious restrictions on who can be covered, the unemployed, and older adults between the ages of 55 and 64 including widows and retired workers and their spouses who do not yet qualify for Medicare. The absence of health insurance for these groups is not only a serious financial matter but poses a significant barrier to needed medical care and undermines both the health and economic security of families. Particularly alarming is the fact that access to health care in this nation is becoming worse not better and the ranks of the uninsured are swelling.

Today, I would like to share with the Committee the latest data on health care costs that face those without health insurance, gaps in health insurance coverage, what we know about the consequences of these gaps in coverage, and suggest ways in which gaps in health insurance coverage could be closed.

Health Care Costs and the Uninsured

Health care costs have risen rapidly in the 1980s. National health expenditures doubled between 1980 and 1987, from $250 billion in 1980 to $500 billion in 1987. In 1980 the average per capita health expenditure was a little over $1,000. By 1987, on average each man, woman, and child incurred health expenses of almost $2,000. If current policies remain unchanged, this will increase further to $2,500 in 1990. As a percent of the Gross National Product, health expenditures have increased from 9.1 percent in 1980 to 11.2 percent in 1987 -- a two percentage point increase in only seven years. This is projected to increase to 12 percent in 1990, and will reach 15 percent by the year 2000 if nothing is done.

These figures are truly astounding -- but their impact on those Americans without any health insurance coverage is devastating. If a patient is hospitalized today, the average cost of a hospital stay is over $3,900 -- compared with $1,800 in 1980. Physician fees have increased eight percent a year in the 1980s -- three percentage points faster than the Consumer Price Index. The Medicare premium has increased from just over $115 a year in 1980 to about $300 today. The Medicare hospital deductible has increased three-fold from 1980 to 1988, up from $180 in 1980 to $540 today.

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Health Insurance Coverage in the U.S.

People under age 65 obtain health insurance coverage in three major ways: they receive group health insurance provided by their employer, they purchase health insurance individually from private health insurance companies, or they qualify for coverage under the Medicaid program.

Coverage under an employer health plan is the most common way in which the nonelderly obtain health insurance coverage. About 132 million nonelderly people, or about two-thirds of the nonelderly, have employer-provided health insurance coverage. About 24 million are covered by Medicaid or other public programs. About 16 million purchase private health insurance coverage individually, leaving an estimated 35 to 37 million uninsured.

The common impression is that the uninsured are outside the work force -- mostly young adults who have not yet found jobs. This is not the case. Surprisingly, over half of the uninsured, 19.6 million people, are in families where at least one member has a full-time job working 35 or more hours per week. Two-thirds of the uninsured are in families where at least one member works at least 17 1/2 or more hours per week.

About one-third of the uninsured are children under age 18. Half of the uninsured are parents or other adults between the ages of 17 and 45. The remaining sixteen percent of the uninsured are split equally between older adults between the ages of 45 and 54 and between the ages of 55 and 64. Many of these older adults are widows or spouses of retired persons who do not yet qualify for Medicare.

Nearly all of the uninsured have modest incomes. About one-third have incomes below the poverty level. Only 20 percent have incomes greater than three times the poverty level. Individual purchase of private health insurance is not economically feasible for most of the uninsured. Individual plans typically have inadequate benefits and charge premiums well in excess of actual benefit outlays.

Medicaid fails to cover the majority of the poor. Absence of Medicaid coverage among the poor occurs because states set income eligibility levels well below the federal poverty level and because categorical restrictions limit coverage largely to one-parent families -- excluding two parent poor families, childless couples, and single individuals.

The majority of workers receive health insurance coverage from their employers. However, 22 million Americans in families where one person works at least half-time fail to receive coverage. Gaps in employer-provided health insurance coverage occur because such coverage is optional for employers. About half of all employed uninsured persons work in firms with fewer than 25 employees. Employer-provided health insurance coverage is particularly low in certain industries -- including agriculture, construction, retail trade, and services. Coverage of workers is lower in the South and West than in the North and Central regions of the country.

To a considerable extent health insurance coverage in this country is a matter of luck. Those fortunate enough to be employed by large, unionized, manufacturing firms are also likely to be fortunate enough to have good health insurance coverage. Those who have modest incomes, live in the South and West or in rural areas, and those who are black or minority group members are more likely to bear the personal and economic effects of lack of insurance and the consequent financial barriers to health care.

Health insurance coverage has been getting worse not better. Several factors are responsible for this:

- The growth of jobs in the service sector which tend not to have health insurance coverage.
- The growth of jobs in smaller firms.
- The increasing tendency for employers to require employee contributions to health insurance premiums, including paying the full cost of dependent coverage.
- The growth in one-parent families, which are less likely to have health insurance coverage than two-worker families.
- The growth in the number of adults between the ages of 17 and 45 which are less likely to have health insurance coverage.

While considerable further analysis and research will be required to sort out the independent contribution of these and other factors, it is clear that gaps in employer-provided health insurance are responsible for a large portion of the uninsured population.

The Uninsured and Access to Health Care

A new report on access to health care in 1986 recently released by the Robert Wood Johnson Foundation contains evidence on the deterioration in access to health care in the 1980s. Thirteen and one-half million people reported not receiving medical care for financial reasons. An estimated one million individuals actually tried to obtain needed care but were turned away. Several indicators suggest that progress in improving access to health care for the poor and minorities has been reversed between 1982 and 1986.

The Robert Wood Johnson Foundation access survey found particular problems for the uninsured. The uninsured are one-third more likely to be in fair or poor health than the nonelderly insured. Yet despite their poorer health status, the uninsured receive 27 percent fewer physician services and are hospitalized 19 percent less frequently than the insured. One-fifth of the uninsured with chronic illness did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms (e.g. bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet) did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in the year.

Clearly, absence of health insurance coverage is not only a serious financial problem it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

Alternative Approaches to Closing the Gaps in Health Insurance Coverage

It is urgent that action be taken to provide at least some minimum health insurance coverage for all Americans. In evaluating the economic impact of any one approach to dealing with this problem, it is important to consider the alternatives. The major approaches which could be followed to close the gaps in health insurance coverage include:

- o Expanding public programs such as Medicaid or Medicare to cover the uninsured or establishing a new public program,
- o Subsidizing the purchase of individual private health insurance through federal or state government funds,
- o Taxing hospitals or private health insurance plans to create a pool for paying for care for the uninsured, or
- o Requiring employers to provide health insurance coverage for employees and dependents.

The first of these alternatives would require substantial new taxes from corporations or individuals. Given current governmental budgetary problems, public funds might be better targeted on those low-income uninsured falling outside the workforce. In addition since some of the working poor and near-poor have private health insurance coverage through employers, public coverage would displace current private coverage and add considerably to public outlays.

The second approach would also require additional taxes to pay for subsidies of an inherently inefficient type of health insurance coverage. Individual health insurance plans run administrative costs 30 to 50 percent of benefits, compared to 3 to 5 percent for Medicare and Medicaid. Public monies would go further by directly covering the uninsured under Medicaid or Medicare than by indirectly subsidizing coverage under individual private health insurance plans.

The third approach of taxing hospitals or private health insurance plans would shift the financial burden of covering the uninsured onto the insured. Those employers providing coverage for their workers would be doubly burdened -- picking up the costs of their own workers plus the cost of workers in firms not providing such coverage. In a given industry, firms providing health insurance coverage for workers would be at a serious competitive disadvantage to those firms not providing such coverage.

In the light of these alternatives, requiring minimum employee health insurance coverage has much to commend it. It would minimize new taxes required to fill the gaps in health insurance coverage. It would build on the current system of employer-provided private group health insurance. It would spread the cost of expanded coverage more equitably among firms, rather than concentrating the burden on those firms voluntarily electing to provide coverage to their workers. It would permit limited public funds to be targeted onto low-income individuals not covered by employer plans.

Minimum Employer Health Insurance Coverage

The Employee Health Benefit Improvement Act of 1988 introduced by Chairman Stark represents an important step toward assuring better health insurance coverage in this country. This plan would provide coverage to all workers and their dependents who work at least 17.5 hours per week, with special provisions for coverage of farmworkers. Importantly, no employer plan could exclude a worker or coverage for specific health problems because that worker or dependent already had a health condition.

Employers would contribute at least 80 percent of the premium for both workers and their dependents. Low-income employees would receive some assistance in meeting their share of the premium through a health insurance income tax credit, similar to the existing earned income tax credit.

Under the plan all working families would be protected from catastrophic health care expenses -- through a ceiling on out-of-pocket health expenses not to exceed $1,500 per family, or $1,000 per individual. In addition the bill would help get all children of working families off to a healthy start in life through comprehensive coverage of maternal and infant health care.

The primary criticism raised against such a proposal is that it would be an economic burden on low-wage firms and might result in loss of jobs for low-wage workers. There is some evidence that suggests a 10 percent increase in labor costs might result in a one-half to one percent decline in employment. Applying this to the low-wage uninsured suggests a potential employment loss of under 50,000. However, this job loss would be more than offset by additional jobs of 100,000 or more in the health sector to provide new services.

There is reason to believe that even these modest adverse employment effects are overstated. First, the plan outlined does not constitute an excessively burdensome plan. Second, the labor market for entry-level workers is tightening with the drop in fertility in the mid-1960s leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely. Third, the minimum wage has not been increased since 1981, so that the cost of entry-level workers has declined in real terms over the last six years. Fourth, the types of jobs that are potentially affected are largely in the service sector or retail trade which are not as sensitive to international competition.

Another concern is that small firms would not be able to purchase health insurance economically. The option of purchasing coverage through state pools would assure even the smallest firms of the availability of coverage. Consideration might be given to holding premiums in the state pool to no more than 20 percent above the average premium in the state.

Medicaid Coverage

Requiring employers to provide coverage for their workers and dependents would add 22 million more people to health insurance coverage, and drop the number of uninsured to less than 15 million. Most of the remaining uninsured are poor or near-poor. While state pools might be of some assistance to the 5 million with incomes above twice the poverty level, most of these individuals will remain uncovered. Another step that needs to be considered is expansion of Medicaid coverage to cover all poor uninsured, as well as permitting the near-poor to purchase Medicaid on a sliding scale basis.

Under this proposal, the Medicaid program would be expanded to provide acute health care benefits to the entire population falling outside employer mandated coverage and Medicare coverage. It would provide complete coverage to all poor and premium-financed coverage to others. Medicaid would be a secondary payer for individuals covered under employer plans or Medicare.

The provisions of this component include:

- Automatic coverage of all individuals under the poverty level.
- Optional purchase of Medicaid to all nonpoor not covered under an employer plan on a sliding scale premium basis.
- The Medicaid program would cover the current mandatory benefits plus prescription drugs, without arbitrary limits on amount, duration, or scope of benefits. For individuals purchasing coverage with a sliding-scale premium, modest cost-sharing provisions could be included.

Summary

The private-public partnership set forth here is an economically and administratively feasible approach to remedying the gaps in health insurance coverage that threaten the health and well-being of a significant portion of our nation's population. While the specific details could be modified, or even more modest steps taken incrementally to close these gaps in coverage, the plan proposed here should be carefully considered and debated. I congratulate the Committee for undertaking serious examination of ways in which such gaps in coverage can be eliminated. Thank you.

Chairman STARK. Mr. Reinhardt.

STATEMENT OF UWE E. REINHARDT, PH.D., JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NJ

Mr. REINHARDT. Thank you, Mr. Chairman.

I feel honored to have been invited before this committee to discuss with you solutions to the problems of Americans without health insurance coverage. Alas, I am not convinced that this is an issue that burns deeply in the soul of the American people. I have watched the American people now for 20 years on this issue and am beginning to wonder if many people really came to be their poor brothers' and sisters' keepers in health care.

I find it significant, for example, that the New York Times did not even feel compelled to put Mr. Dukakis' proposal, made on Tuesday into the first section of the Times. It relegated to page B–6 of the second section. That demonstrates the "keen interest" of that great newspaper in this particular issue.

In my testimony, on page 8–A, I present a table that indicates responses from a nationwide survey to the question: "How much per year would you be willing to pay in higher taxes or increased insurance premiums to cover the cost of health care for those who cannot afford it?" 29 percent, almost one-third of the respondents said: "Nothing!" Another 18 percent would be willing to pay only $1 to $25.

Thus, I commend you doubly for holding these hearings. You are fighting a lonely and uphill struggle against a people whose soul and heart, I fear, have grown severe calluses in the last 10 years.

There arose earlier the question of precisely how many uninsured there are in this country: is it 37 million or "only" 34 million. I don't think that such bean counting is important. There are somewhere between 30 and 40 million uninsured at any point in time. It is a large number either way.

Fortunately, not all of these uninsured get sick every year. But those who do do often have trouble getting help. Surveys have shown that nearly 1 million American families are refused needed services every year for want of being able to pay.

Chairman STARK. Is that the figure from Robert Wood Johnson Foundation? I thought it was 1 million people, but it is families?

Mr. REINHARDT. I think it is families, yes.

It is sometimes useful to visualize denied care in real life. For example, in the New York Times, in August of last year, it was reported that "A woman shot in the back who had no health insurance had to wait 13 hours before doctors could find a hospital to accept her for surgery."

Earlier, in the Wall Street Journal, a paper not known for its left-wing leaning, there appeared the story that "A pediatrician in Rock Hill, South Carolina wanted to transfer a 3-year-old girl to a better equipped medical center, but her family has no health insurance and two hospitals turned her down."

Upper-income-class Americans, as most of us here in the room, just have to close your eyes and imagine that this were their little girl. How would these well-to-do people feel searching the countryside for someone to help their precious little daughter?

Much attention has been paid to the Pledge of Allegiance lately. I would propose there is a way more powerful pledge than recitation of the traditional pledge. What about standing up and telling every American child: "I pledge that if you ever fall sick, we, the United States people, will make available to you the necessary care at the nearest hospital, and if your parents cannot pay for that care we, the people of the United States, will"?

I begin with these remarks because we must not abstract from the moral implications of this sad American story. As I remark in my testimony, our health system must be a Soviet textbook writer's delight. They don't have to make up stories to malign us. All they have to do is Xerox copies from our daily press, and we are properly maligned.

Dr. Davis carefully surveyed the proposals before us. There is, of course, the option of national health insurance on the Canadian model. As an erstwhile Canadian who lived there in poverty, I can assure you that it is a wonderful system. I admire it from afar.

I have concluded, however, that it is not a feasible option for Americans at this time, or perhaps ever. We would have to have a much stronger sense of nationhood to run a national health insurance system. Unfortunately, we are not that cohesive a Nation. We lack the sense of community it would take to operate a true national health insurance program.

The other option is employer-mandated benefits, for which there have been a number of proposals.

You quite interestingly remarked that it is actually an old Republican idea. Just to be sure that was understood, I brought President Nixon's health message February 18, 1971. You might want to enter that into the record, if only to remind people who call that a socialist idea that they are calling President Nixon a Socialist. That, of course, would be a new twist in American policies.

Chairman **Stark**. He is now being referred to as a Californian.

Mr. **Reinhardt**. I congratulate you for introducing H.R. 4951. Although I am known as an opponent of employer-mandated benefits, we must give the proposal credit where it is due. The first major credit, as Dr. Davis mentioned, is that it does build upon the American tradition of tieing health insurance to the workplace. We are used to that approach. However, I do worry about the Financial Accounting Standards Board's new rulings that would compel an American executive to practice candor in talking to shareholders. I am referring, of course, to the rule that will force corperations to acknowledge as a liability the actual present value of health benefits promised retired workers.

Some companies, for example, Allied Signal, say that that liability now equals half their net worth. When that becomes known to the shareholders and on Wall Street, American executives may wish to re-think the role they wish to play in employer-paid health insurance. It is that threat, this cloud on the horizon, that makes me worry about the mandated approach in general.

There are some other down sides, as Dr. Davis mentioned. Mandated benefits are payroll taxes that have the usual effects of payroll taxes. Dr. Davis talked about unemployment and mentioned we don't know how large that effect is. But there is another pernicious feature of this particular payroll tax and it is the following: If an employer cannot shift that tax forward to customers in the form of higher prices, then the employer has to shift it backward to the employee and say to him or her: "Look, I used to pay you $12,000 a year. Now I am mandated to give you this insurance. Therefore I am now going to pay you $10,000 cash and I will give you this mandated package." So we really have mandated to the individual to purchase, with cash, insurance that he or she couldn't afford to begin with.

It is very regressive tax. That is what I oppose mandated benefits, in principle. But I say on page 6 that, if mandated benefits is the only game in town, I would wholeheartedly support it, and for that reason I have never testified against it.

Now, the proposal I offer in my statement is a different one. My plan would be based on honest taxation and would operate roughly like this.

Every American would be automatically covered by a Federal fail-safe system that would deliver health care through HMO's that might bid competitively with a Federal and State administrative apparatus, or negotiate fees and charges with that apparatus.

Every American would be in that play. Thus, there would be no more uncompensated care.

Americans would pay for that privilege on their 1040 tax form. On that form, the household would be taxed *x* percent of adjusted gross income for the fail-safe plan. *X* might be 12 percent or so. But one could calibrate the value of *x* as a policy parameter.

If the household had a better private insurance policy, it would clip a copy to the 1040 and thus would be excused from the fail-safe tax. I would then, as a tax-code writer, proceed as follows:

On line 13(a) of the 1040 it would say: "Do you or do you not subscribe to the Judeo-Christian ethic?" (Of course, we should throw in the Confucian and Islamic ethic, as well). "If you do, you pay 1 to 1½ percent of adjusted gross income to underwrite this principle. If you do not, you are excused from this tax, but we will publish your name in the Federal Register."

I have a hunch that if we earmarked the tax and if the political leadership were to explain this to the people, that the American people might yet own up to the self-congratulatory dictum President Reagan reiterates so often: That we are "the most generous people on earth."

But leaders would have to explain it to the American people.

I think the advantage of my plan is that it would not burden small entrepreneurs with having to own up to a law of mandated benefits that they probably wouldn't understand. Furthermore, my plan calls for honest taxation.

You could modulate the plan by changing the tax rate "x". I believe that in the era of labor shortage, the bulk of the American people would continue to get their health insurance from their employer, but on a voluntary basis.

Most employers would probably have a strong interest voluntarily to offer employees health insurance.

I remark on the Federal deficit in my testimony and I would offer the following observation on it:

If we take the collected wisdom of the following well-known economics professors: Professor Robert Eisner of Northwestern, Professor Robert Barro, Martin Feldstein, Benjamin Friedman and Larry Summers of Harvard, Professor Kotlikoff of Boston University and Professor Robert Heilbronner of the New School of Social Research, and if we instilled their scholarly insight into the deficit into one sentence, here is how that sentence would read: Depending upon assumptions, definitions and accounting methodology, there may or may not be a Federal deficit, and even if there were one, it may or may not harm the nation' economic growth.

I argue that, if our profession collectively offers no better insight on the deficit, why should Congress feel compelled to hold sick and poor Americans hostage to this imagined monster?

I urge you not even to think about this deficit when you consider this issue. The problem of the uninsured requires us to move onto a higher moral plain.

Thank you.

[The statement of Mr. Reinhardt follows:]

AN ALTERNATIVE TO MANDATED HEALTH-INSURANCE BENEFITS

Uwe E. Reinhardt, Ph.D.
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My Name is Uwe E. Reinhardt. I am the James Madison Professor of Political Economy at the Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, N.J. I am pleased and honored, Mr. Chairman, to be invited before your Committee to comment on potential solutions to our nation's millions of uninsured citizens.

In this statement, I would like to comment critically on one such solution--namely, mandating business firms to provide employees with health insurance--and suggest an alternative that does not place upon the shoulders of business tasks that properly belong in the government's portfolio. My statement will draw heavily upon work I have published previously[1]. I shall begin with a brief look at the dimensions of the problem before us.

I. MISERY AMIDST PLENTY

If one took stock of the American health system at this time, one might fairly conclude the following:

> ***The American health system offers wealthy or well-insured Americans a wide choice among a rich abundance of technically sophisticated resources, which explains why American health care is by far the most expensive in the world and which, in turn, may explain also why Americans find it so hard to share these expensive blessings with their poorer fellow citizens. If one takes into account not only the purely clinical quality of health care, but also the ethical quality of the entire system, then I judge it fair to conclude that the American health system offers the nation's citizens both the very best and the very worst health care to be found in the industrialized world.***

Recently the New York Times carried a story according to which a poor woman in Florida, wounded with a bullet in her back, had to wait 13 hours for surgery because she was uninsured and hospitals in the area were reluctant to take her in. Newspapers around the country have carried similarly disturbing vignettes that appear to be occuring with increasing frequency, as pressure on the delivery system to contain costs through price-competition increases[2]. These vignettes represent what I mean by "the worst health care to be found in the industrialized nations." I cannot imagine that they could possibly occur in neighboring Canada or, for that matter, in any other industrialized nation.

At this time, some 30 to 40 million Americans are without protection against the financial ravages attending serious illness. Close to half of these are fulltime workers. Close to one third are children under the age of 18. As is well known--or should be well known--roughly one third of all Americans living below the official poverty line are children, and over 22 percent of all American children now live below that official poverty line. In 1985, that line was an annual income of $ 7,230 for a non-elderly family of two and $ 10,900 for a non-elderly family of four.

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[1] See especially Uwe E. Reinhardt, "Are Mandated Benefits the Answer?" Health Management Quarterly, First Quarter, 1988; pp.10-14 and Uwe E. Reinhardt, "Health Insurance for the Nation's Poor," Health Affairs, Spring, 1987; pp.101-12.

[2] For examples of this sort, see Uwe E. Reinhardt, "Hard Choices in Health Care: a Matter of Ethics," in HEALTH CARE: How to Improve it And Pay for it, Washington, D.C.: Center for National Policy, April, 1985; pp.19-31. See also the excellent series of reports on the problem in The Dallas Morning News, April 25-27, 1987.

Some of the uninsured could undoubtedly afford to purchase health-insurance out of their own resources, if affordable individual policies were actually available to them in the market, say, at a price equivalent to group health-insurance. In 1987, the annual premium for one such a policy would have been between $ 2,100 and $ 4,500 for a family of four, and between $ 780 and $ 1,500 for a single individual, depending on location. In addition, the insured would shoulder deductibles and coinsurance exposing them to a maximum annual out-of-pocket expense of $ 3,000.

Unfortunately, some major commercial insurers do not even offer individual health-insurance policies any more. If they do, they must price them at a multiple of the premiums for group insurance, because there are added marketing and administrative costs and there is the ever-present problem of adverse-risk selection by individuals. At those higher levels, however, the premiums can easily exceed the economic capacity even of households we would not classify as "poor," as will be clear to a thoughtful person from Table 1 overleaf.

In Table 1 it is shown that, in 1986, roughly 40 percent of all households with more than one person had a family income of $ 24,000 or less. It is a figure possibly much beneath the imagination of those who manage this nation's health-care resources, those who fashion its health policy, health economists who invent ever more fanciful "market strategies" for "consumer choice" in health care, and lobbyists who are well paid to help forge national health policy in ways desired by some client. I would invite all of these persons to contemplate carefully the data presented in Table 1, not only to luxuriate in their own good fortune, but also at least to try to imagine the real-life scenario corresponding to the economist's dream that, say, a family of four in, say, the second lowest income quintile be permitted to "choose" "freely" among alternative health insurance "options" available in the "market place." Failure on the part of the elite to perform that feat of imagination could be one of the major tragedies of contemporary American health policy.

II. HEALTH INSURANCE FOR LOW-INCOME, UNINSURED AMERICANS

As already suggested earlier, in our never ending squabble over who should finance the care of poor, uninsured Americans who fall seriously ill, we have come to deny far too many of them access to doctors and hospital beds of which we claim to have too many. This paradox ought to be a bane for proud Americans, if only because it is apt to be such a boon to America's detractors abroad. In fact, America's failure so far to resolve this problem must be a Soviet textbook writer's delight.

Americans who are troubled by the plight of the uninsured can take inspiration from the fact that no other industrialized nation finds itself in a similar fix, which suggests that the problem _is_ capable of solution among people of imagina-

TABLE 1

THE DISTRIBUTION OF MONEY INCOME IN THE U.S.
1986

QUINTILE of Households or Individuals	HOUSEHOLDS WITH TWO PERSONS OR MORE		UNRELATED INDIVIDUALS	
	Percent of Total Income Received by Households	Upper Income Threshold for Quintile	Percent of Total Income Received by Individuals	Upper Income Threshold for Quintile
Lowest Quintile	4.6%	$13,886	3.5%	$5,128
2nd Quintile	10.8	24,020	8.8	9,260
3rd Quintile	16.8	35,015	15.2	15,334
4th Quintile	24.0	50,370	24.5	25,000
Upper Quintile	43.7	—	48.1	—
Top 5 Percent	17.0%	$82,273	19.1%	$40,600

Source: U.S. Department of Commerce, Bureau of the Census, Money Income and Poverty Status of Families and Persons in the United States, Current Population Series P-60, #157, July, 1987; Table 4.

tion and goodwill. Alas, the solutions adopted elsewhere tend to be distinctly un-American: they have involved the socialized financing of health care under universal, national health-insurance and, in the United Kingdom and Scandinavia, the socialized production of health care as well.

National health insurance has long been anathema to Americans--or at least to those who determine American health policy. I do not consider it a politically viable option at this time, and it probably never will be. We are left, therefore, with the question whether there are other options more closely tailored to this nation's soul. One of these would be H.R. 4951, the proposed legislation before this Committee.

A. Employer-Mandated Health Insurance

As I understand H.R. 4951, it would delegate the bulk of this social problem to the good offices of the private business sector by requiring every employer to provide a mandated set of health insurance benefits to every employee working more than 17.5 hours per week. Extended to include the employee's dependents, that mandate alone would bring somewhere between one third to three quarters of the now uninsured into the protected fold, depending upon the measure's impact upon employment of marginally profitable workers. The remainder of the uninsured would then be brought into the fold by means of risk pools in each state and tax-deductions or -credits for self-employed persons.

One can assess the merits of this approach by means of a T-account, with a debit and a credit side, and then take an overall balance of the measure. The latter, of course, will inevitably be sub subjective.

The first credit is earned by employer-mandated health insurance is its bipartisan origin. Seasoned observers of American health policy will recognize in the proposal an old Republican idea, namely, the core of former President Richard Nixon's Health Message to Congress dated February 18, 1971[3]. Because the general idea behind the bill now enjoys support among Democratic members of Congress as well[4]--as it decidedly did not in 1971--one must impute to it a fairly broad political base. The measure can be derided as a "socialist program" only by attaching that label implicitly also to former President Nixon and as "inadequate" only by questioning the commitment to the poor by leading Democrats.

A second advantage of employer-mandated health insurance is that it builds upon the American tradition to tie such coverage to the work place. That approach has served millions of Americans well, albeit at an increasingly burdensome cost to employers. The latter circumstance, of course, raises the question how much longer American business will continue to support that approach as enthusiastically as it has in the past, especially when the health sector presents to business the apparently staggering bill for unfunded and hitherto unacknowledged health-care benefits promised to retired workers. We shall learn more about the attitude of business after the Financial Accounting Standards Board (FASB) has forced American business to report honestly to shareholders the magnitude of the liabilities already incurred on that one item. The FASB's attempt to mandate honesty in these matters may well sour the mood among America's business executives as they contemplate the virtue of employer-paid health benefits.

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[3] See Health Message from the President of the United States Relative to Building a National Health Strategy, February 18, 1971, House Document No. 92-49, 92nd Congress, 1st. Session, Washington, D.c.: U.S. Government Printing Office, 1971; pp.14-19.

[4] H.R. 4951 is similar to Senator Kennedy's S.1265.

A third credit earned by mandated benefits, certainly in the eyes of politicians, must be the fact that such mandates allow legislators to pursue preferred social goals without having to support them explicitly with added tax-revenues. Because mandated benefits are hidden taxes, they are ideally suited to the current era in which honesty on the matter of taxation amounts demonstrably to political suicide. Mandated benefits are therefore likely to be supported even by concerned and well-intentioned politicians who would have preferred honest, explicit taxation.

Among responsible legislators, however, the political allure of mandating employer-paid benefits ought to be tempered by its potential economic side-effects. Mandated benefits are payroll taxes whose ultimate incidence on the customers, owners and employees of business firms is not easily predicted. Their effects on employment, output and prices are therefore not easily predicted either. Therein lies the first debit to be lodged against the measure.

The owners of business firms (be they proprietors or shareholders of corporations) may, of course, seek to reduce their own share of the tax burden simply by passing on the payroll tax to customers, in the form of higher prices. But high price-sensitivity on the part of customers may limit the degree of this forward shifting. If so, employers will seek to shift the tax backward to employees by substituting the mandated benefits for cash wages that would otherwise have been paid. In that case, however, the ultimate incidence of the tax will be quite regressive. One would effectively force even low-income wage earners to purchase government-mandated health-insurance benefits at a tax-premium that does not vary by ability to pay but instead takes on the form of a head-tax. For employees in the lowest quintile of the income distribution (see Table 1 above) such a head-tax could be devastating.

If minimum wage laws or other downward rigidities make it impossible to shift the cost of mandated benefits backwards, and if price-sensitivity among the firm's customers make it difficult to shift it forward, then the longrun effect of the tax is likely to be the substitution of labor-saving capital equipment for the [now more expensive] input of labor or, worse still, simply a reduction in output and employment. At least some of the working uninsured may thus be transformed by mandated benefits into unemployed uninsured. How important that effect will be remains an open empirical question at this time.

There is evidence that the bulk of the employed uninsured work for small business enterprises. The latter tend to be the cutting edge of the economy. They have provided the bulk of new jobs created during the most recent economic expansion. One must wonder whether it is wise to saddle this entrepreneurial element in the economy not only with the fiscal burden inherent in mandated benefits but, worse still, with the bureaucratic burden of demonstrating compliance with the typically complex statutes passed by our legislators. There would doubtless arise yet another class of consultants deriving their livelihood from interpreting the government's wishes to the laity. Mandated health-insurance would also, of course, drive these entrepreneurs into the waiting arms of an insurance industry that has not traditionally distinguished itself in servicing small business firms.

Taking a balance of these debits and credits, I conclude that legislators who wish to assist the poor and boost the supply side of the American economy ought to embrace mandated benefits only if these are deemed literally the only way to keep America in the Club of Civilized Nations. If mandated benefits were in this sense the "only game in town" I, for one, would endorse them wholeheartedly. The question thus arises: Are mandated benefits truly the "only game in this political town?"

B. A Federal Fail-Safe System

Americans not afflicted with an instinctive aversion to honest federal taxation might contemplate an alternative, all-American approach, namely, a Federal Fail-Safe Health Insurance program primarily for the lower-income groups and financed substantially by earmarked Federal income taxes[5].

Such a program, which would be available automatically to every American resident, would provide the insured with comprehensive health services, including specified preventive services for expectant mothers and for children. These services would be delivered by managed-care systems such as a Health Maintenance Organizations or a Preferred Provider Organizations under competitively-bid or negotiated contracts with the Fail-Safe system and, of course, under sustained external monitoring of the quality of care. Emergency care could be procured everywhere at predetermined rates, perhaps those established under the federal Medicare program.

Because "actuarially fair" contributions to such a scheme would violate our professed social ethic--"actuarially fair" premiums imply the ethic that unlucky sick individuals should pay higher health-insurance premiums than lucky healthy ones--the proposed Fail-Safe system would be financed on the basis of ability to pay, as is customary virtually everywhere else in the world. One approach might be to include on the 1040 tax form a line calling for a health-insurance tax equal to X% of Adjusted Gross Income above a certain threshold. Taxpayers would have to pay that tax unless they clipped to the 1040 a copy of an equivalent or better private health-insurance policy, in which case taxpayers might be asked to contribute only a much smaller tax earmarked for indigent care. It would be the individual's price for luxuriating in what we so arrogantly[6] hail as the "Judeo-Christian ethic"--the social ethic prescribed in most religions that one be one's poor brethrens' keeper. Any cost of the program not covered by these explicit tax rates would have to come from General Revenue, as do about $ 50 billion of Federal health outlays now.

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[5] For a lengthier description of this proposal, and its underlying rationale, see Uwe E. Reinhardt, " Health Insurance for the Nation's Poor," Health Affairs, Spring, 1987; pp.101-12.

[6] I inject this adjective in deference to my Chinese wife who regularly lectures me on the virtues of Confucian and Buddhist thought.

The tax rate X is an important policy parameter. It could be set, perhaps progressively, to discourage excessive reliance on the Fail-Safe system by the middle- and upper-income groups. In the impending era of the labor shortage, the majority of Americans could probably prevail upon their employers to provide health-insurance coverage, but on a voluntary basis, as before. Thus, the Fail-Safe approach could be structured so as to preserve the private-sector pluralism of which Americans are so fond and for which they have always been willing to pay a substantial premium above absolutely necessary health-care costs. I judge the ability of citizens to opt out of the Federal Fail-Safe program an important design parameter in the American context, because Americans harbor such a manifest distrust toward their government, and many Americans find it outright distasteful to deal with their government even when that government offers them a good proposition.

The presence of the Federal Fail-Safe system would eliminate once and for all the providers' problem of "uncompensated care" and the attendant cost-shifting to commercial insurers and, thence, to the payroll accounts of business firms. It would also remove from the uninsured the stigma of being "health-care beggars" forced, in case of illness, to cast about for the uncertain noblesse oblige of kindly providers of care. The system would be federal on the thesis that America is not just a place, but a genuine nation, one whose government should set a floor beneath which no American is allowed to sink in health care.

There is no reason, however, to preclude state and local governments from the administration and partial financing of such a system. Many other nations--for example, Canada and West Germany--adopt that form of partnership in their health systems.

III. FEDERAL HEALTH POLICY, TAXES, AND THE FEDERAL DEFICIT

It may be judged sheer madness to propose a major new Federal initiative in health care at a time when the nation considers itself victimized by a huge Federal deficit. Indeed, proponents of employer-mandated benefits often argue that this hidden form of taxation is the only effective way to sidestep the obstacle of the Deficit.

An economist can offer several observations on the linkage between Federal fiscal policy and health policy.

First, America is not a victim of the Federal Deficit. That deficit is wholly man-made and could easily be eliminated by the very persons who created it in concert--Congress and the Administration.

Perhaps one reason why those who created the Deficit have not felt compelled to eliminate it is the great uncertainty that currently prevails over the role deficits play in longterm economic growth. On this point, the so-called "science of economics" has been singularly uninspiring. If one distilled into a few sentences the scholarly insights now being offered by prominent American economists, each with a Ph.D., and each teaching at a prominent American university[7], one would fairly have to offer the following summary:

> ***Depending upon definitions and accounting methodology, there may or may not be a Federal Deficit and, even if there were one, it may or may not harm the nation's economic prospects.***

If the economics profession collectively offers society that kind of wisdom, one may forgive society at large, and the Congress, for exhibiting no sense of urgency over the Deficit. And that being so, it is certainly not clear why one should let the health care of poor American citizens hostage to this ill understood "monster." As a professional economist and health-policy analyst, I urge the Committee not even to think about the Deficit as it weighs the pros and cons of alternative health-insurance schemes for the poor.

It may be asked, however, whether the American body politic might be ready to countenance the explicit tax levies called for by the proposed Federal Fail-Safe system. Here the evidence is just as confusing as are our perceptions of the Deficit.

In a recent paper by Robert J. Blendon[8], the author concludes that "contrary to the views of many of the nation's leaders, in 1986, most Americans (54%) believed that the United States currently spends too little rather than too much (9%) for health services. In fact, given a choice, 63% of the public favored making health care more available to everyone who does not yet have it rather than lowering the nation's health care spending." Other surveys suggest that, if Federal spending is to be cut for the sake of the Deficit, most Americans would not like health care spending for the elderly or the poor to be among the targets.

On the other hand, in a recent survey published by the Health Management Quarterly[9], questions on willingness to pay for indigent care drew the responses shown in Table 2 on the next page. These responses do make one wonder whether Americans really are prepared to "put their money were their mouth is" when they profess their allegiance to nationhood and to lofty precepts on the distribution of health services.

I conclude from the confusing evidence that the American people possibly could be induced to finance care for their poor fellow citizens adequately if they were educated and led on that point by respected political leaders. One sees here

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[7] I am thinking here of the range of views spanned by Professor Robert Eisner at Northwestern University, Professors Robert Barro, Martin Feldstein, Benjamin Friedman and Lawrence Summer at Harvard University, Professor Lawrence Kotlikoff at Boston University and Professor Robert Heilbronner at the New School of Social Research.

[8] Robert J. Blendon, "The Public's View of the Future of Health Care," Journal of the American Medical Association, Vol. 259,, No.24, June 24, 1988; pp.3587-93.

[9] Gene Pokorny, "Report Card on Health Care," Health Management Quarterly, First Quarter, 1988; pp.3-7.

TABLE 2

RESPONSES FROM 1,508 ADULTS SURVEYED IN 1987 ON
ISSUES IN AMERICAN HEALTH CARE

Willingness to Pay

How much per year would you be willing to pay in higher taxes or in increased insurance premiums to cover the cost of health care for those who cannot afford it?

Nothing	29%
$1-25	18
$26-50	9
$51-75	3
$76-100	6
$100-150	3
$151-200	2
Over $200	5
Don't know	24

SOURCE: Gene Pokorny, "Report Card on Health Care," HEALTH MANAGEMENT QUARTERLY, First Quarter, 1988, p.4.

an opportunity for the members of this Committee and, of course, for the next Administration.

Finally, on the issue of financing, it may be noted that the Federal government directly or indirectly does pay about $ 50 billion or so in Federal funds for health care, over and above the $ 90 billion or so it spends on health care for the aged, rich and poor alike. Furthermore, another $ 30 billion or so in tax revenues are foregone by sheltering from taxation employer-paid health insurance benefits even if these accrue to high-income employees. To argue that one cannot use Federal finance to provide health care for, say, poor American infants because one must extend this tax shelter to even to America's corporate elite strikes at least this observer as dubious social policy.

III. WHITHER MEDICARE?

In principle, the current Medicare program could be absorbed into the proposed Fail-Safe system by applying to the aged the same terms applied to every other American citizen.

As a practical matter, however, that approach might not be politically feasible for some time, nor would it be necessary for the viability of the Fail-Safe program. In the longer run, the Medicare program will sooner or later stagger under the weight of its own unseemly structure, which grants generous benefits to many well-off aged not truly in need of such public beneficence and yet leaves millions low-income aged exposed to the risk of serious financial hardship over illness. When Medicare staggers badly, then might be the time to fuse it with the Fail-Safe system proposed here.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I can't resist as somebody who has been on at least the margins of involvement in economics over the years pointing out it is a little bit tough to say we shouldn't put any weight on what economists tell us about the deficit, but we should put weight on what they tell us about health care.

I think we should put weight on what they say about both, but that is another subject.

I would like to ask both members of the panel for their comments about the present taxation of health insurance. Some of us unsuccessfully have supported the notion there should be a tax cap, which turned out to be a nonstarter.

But I wonder as an alternative and as a possible means of generating some funds and doing all these good things for people who need it, what you would think about concluding the value of the health insurance policy at the tax base to providing credit on individual taxes equal to the value of a reasonable family plan at the 15 percent rate.

I don't know the number suggested, I would have to work it out, but that is basically converting the deduction into a credit. Not to the exclusion of a credit.

Any thoughts on this?

Mr. REINHARDT. If I may—incidentally, I am speaking to you here less as an economist than as a concerned citizen with a remnant of moral sentiments on this issue. As I mentioned, economists have little consistent thought to offer on the deficit and usually no worthwhile thoughts at all on moral issues.

But on this particular issue, I would say very few economists would, in fact, defend the total exclusion of employer-paid health insurance premiums from taxation, and I remark on that on page 8 of my testimony.

You could certainly cap the tax exclusion of these benefits or do as you suggest Congressman Gradison, which I think is a marvelous idea. I find it odd that we find it so hard to use Federal finance to provide health care for poor American infants, all the while extending tax-sheltered insurance to America's corporate elite. It strikes me as a dubious fiscal and social policy.

I would very much encourage your idea to tease out some additional tax monies from the upper income groups who now enjoy these tax shelters, one of the few remaining major tax shelters at this time.

Ms. DAVIS. I have some concerns about the proposal. I think we are pragmatically in a situation where we need to encourage employers to provide health insurance to their workers and I think the notion of making any payment they make on behalf of workers is a disincentive on the employees or on the employers' part to do that.

So I have some concerns about moving in that direction when it is clear the public sector doesn't want to take on the problem of the uninsured. We need to ask employers to do more, not less.

Setting aside my distinguished colleague's comments, I think this is a tax policy issue rather than a health policy issue. If you are asking yourself you want to generate tax revenues what is the best new tax to do it?

And is it taxing the value of employer contribution to health benefit plans? Setting aside the idea of a tax credit, just doing that, is a very regressive thing to do because the value of that is very small as a percent of income of someone making $80,000, is a very high percentage of worker making $15,000 a year.

So it is certainly a regressive sort of financing. So I think there are some concerns about that general approach.

Mr. **Gradison**. I don't want to quibble. However, the present tax system provides the greatest benefit to the higher income folks, but generous tax policies do nothing at all for people at the bottom.

That is about as regressive a system as one could devise. It wasn't devised by sitting down consciously and saying do we want to do it this way.

That is why I suggest the idea of the tax credit so that 80-odd percent of Americans who pay no more than a 15 percent rate would come out about even on it and it would only be people in the higher brackets hit at all and only on the margin.

Ms. **Davis**. I think there is a difference between dollars and progression as a fraction of income. Say they get $1,000 worth of employer health insurance. That is 10 percent of their income.

If we are talking about a worker making $80,000 a year, an employer provides a more generous plan, that is 2.5 percent of their income.

So is it a smaller fraction of their income. I think you get involved in thinking it is $2,000, not $1,000 and not realizing it is more of a burden on the worker.

Mr. **Gradison**. I want to thank both of you for your appearance and what you have had to say. You have highlighted the essential fact of this whole issue, which is that it is at least as much a tax issue as it is a benefit or health issue, maybe more a tax and finance issue.

In terms of what benefits are, I think we can decide in a few hours how to pay for it.

It may take us a few years. It has taken us a long time already. You have given us some suggestions along those lines which we appreciate.

Thank you and thank you very much.

Chairman **Stark**. Mr. Coyne. Mr. Pickle. Mr. Pease?

Mr. **Pease**. Thank you for your indulgence.

Mr. Reinhardt's suggestion for a Federal fail safe system sounds a lot to me like the plan that I worked out in my own bill, which would make good, adequate health insurance available to every American at his or her option, at a price based on a percentage of a person's income.

Your plan has the advantage I mentioned during my own testimony. It covers unemployed people as well as employed, and does not get into the argument of whether we are burdening employers too greatly. Neither does it get us into the argument of whether or not we are having socialized medicine, since delivery would come through existing—essentially private—health providers.

Would you agree that you and I have both come up with a brilliant idea?

Mr. **Reinhardt**. As I listened to your testimony, I asked for a copy of your bill because there wasn't that much difference. The central feature is it is taxation based on ability to pay and the other useful feature is it takes health care out of the payroll expense line and even more so management now is increasingly getting into the management of care, not just the payment for it.

If you are chairman of ALCON that has to compete—of ALCOA, Aluminum Company of America, that has to compete with ALCON, the Aluminum Company of Canada, who doesn't have it, you should have the chairman of ALCOA here and see what he would tell you about that type of uneven playing field.

Mr. **Pease**. Thank you.

Chairman **Stark**. Dr. Davis, if you went to pools of 120 percent, do you have any idea what kind of Federal subsidy we need to subsidize that program?

Ms. **Davis**. My understanding from actuaries that looked at this, particularly in the context of another bill, Senator Kennedy and Congressman Waxman's bill which would require all small firms to purchase their health insurance from a regional pool, is that you could have an actuarily fair premium at about 115 percent, 15 percent above the group rate.

You have all the small businesses, you have competitive bidding among insurers selecting two or three firms to provide that businesses in a large area, you could get the premium down without requiring—getting down into that 115–120 percent range without a subsidy.

Chairman **Stark**. I am trying to assess what opposition there is to providing mandated benefits or universal coverage. I can see a group of what I will call people with a small number of employees, and I am going to exclude the very wealthy and professional people who could easily afford it for their support staff, who don't have much of a bargaining chip. However, the service station and small retailer, hundreds of thousands and millions of small businesses with two, three, four, five employees are a political voice and have to be reckoned with, as opposed to American Airlines who testifies it is great for all American business.

I am not too sure where the insurance industry is on this. If they can offer a policy—Federal benefits are enough below the desirable level of benefits that I think we can buy off the insurance industry. Then how do we sell our opposition, how do we get the employer to swallow the spinach before he gives his employees the dessert? Any ideas?

Mr. **Reinhardt**. Well, as you mentioned, some large employers have testified before, in favor of mandated benefits—for example, Mr. Crandall of American Airlines. These employers are now paying for indigent care, but capriciously, through cost shifting.

Under mandated benefits the burden will be shared more fairly. There would be a more level playing field.

Chairman **Stark**. I think as they begin to face the accounting changes, that is going to become more apparent to them and I think that takes care of it. Not the small business.

Mr. **Reinhardt**. Not the small. The small business community—I don't know whom they will rally around, maybe the U.S. Chamber of Commerce—but they have vehemently opposed mandated.

They often ask me to testify against mandated benefits on their behalf. The only reason I don't is that they have nothing better up their sleeves. Purely destructive criticism is not effective in this case. It is irresponsible.

That is why I came up with something better that I thought would solve the small business firm's problem and yet keep us a civilized nation.

If I were a doctor or hospital executive, I would have second thoughts about mandated benefits, because it will confront these providers with thousands of very angry small business people who feel they have been forcibly driven into the arms of the big bad wolf—the insurance industry and the providers behind that insurance industry.

Mandated benefits will make life hard for providers, I am sure. Even so, when everything is said and done, I would wholeheartedly support this bill and, in fact, I really do if I have a sense that my proposal, or Mr. Pease's proposal, has no chance.

Chairman STARK. Why would providers not welcome this? I have always suspected risk in the uncompensated carrier is much less than the providers would plea to us when they are asking for higher fees. Is it such a minimal problem in your opinion that that doesn't buy their support, the idea that anyone walking in can pay?

Mr. REINHARDT. We have to look at the longrun dynamics. More American business men and women already are asking for more regulation of providers. If there are enough of these pleas out there, then providers will face precisely the regulatory mechanisms they have feared all along.

It is what's down-the-road from us that would worry me if I were a provider.

Ms. DAVIS. I think it differs by providers. What we know about care—first of all, they are not getting the care they need, but of those that are getting care, fewer and fewer proportionate hospitals are providing that care and those are the hospitals that are starting to get into financial difficulties, so for them certainly to have a bill like yours that would provide health insurance to two out of three of these uninsured individuals will be a great relief to these hospitals.

One of the biggest sources of uncompensated care is for pregnancy, for delivery. So to have coverage of all working families under your plan, particularly the comprehensive prenatal and delivery care would be something that would be very much welcomed.

Chairman STARK. I want to thank you both.

I hope we can call on you again over the next couple of years. Whatever happens in November, I think this is an issue that we will need to address in the coming years. We appreciate your counsel and we will see you back again soon.

Thank you both very much.

We will recess briefly for a vote and return for our next witness, who will be Mr. Jack Meyer, the president of New Directions for Policies.

[Recess.]

Chairman STARK. Our next witness is Jack Meyer, president of New Directions for Policies. Welcome back.

Your prepared testimony will be made part of the record in its entirety, and proceed to expand on it, explain it to us, enlighten us in any manner you desire.

STATEMENT OF JACK A. MEYER, PRESIDENT, NEW DIRECTIONS FOR POLICY

Mr. **Meyer**. Thank you. I will just summarize my testimony, Mr. Chairman.

I would like to start by complimenting you and the committee for addressing a serious issue. We certainly have to do something about the 35 to 27 million people who have no health insurance.

Doing nothing is unacceptable. I urge that as we consider what to do, we look at the total resource cost and not just the cost of the government, as we do this, mandated benefits may not be the preferred approach.

I state in my testimony a preference for a different approach which gets the Government into spending a little money. I think it would make sense to zero in on those who cannot afford to pay for their health insurance, and subsidize them.

One concern I have about mandated benefits is that the proposal sweeps in not only the indigent and near-indigent, but also many people in this country who lack health insurance and should have it, but also have the means to pay for it. I think you will find out around the Beltway, firms that pay $50,000 to someone, and don't offer health insurance, instead of paying them $46,000, and giving them health insurance.

I still want to try to revive such proposals as refundable tax credits or sliding scale vouchers, which actually could be meshed with the kind of tax changes that Congressman Gradison alluded to a moment ago as a partial financing source, a measure I think makes sense. I advocate a self-financed, carefully targeted Government-sponsored approach, instead of a mandate that leaves some of the poor out while protecting that $50,000 a year worker.

I suggest in my testimony some interim steps in that direction that involve welfare and Medicaid. This is not a new agenda, but there are still an awful lot of indigent people who lack health insurance because of the vagaries of our welfare system and the exclusion from Medicaid even though they are poor.

These welfare reform steps and mandated benefits for workers are not mutually exclusive. We could do some of each. I do express a preference for targeting public assistance to the needy, and I think the resource costs would be much lower than under mandated benefits.

The second point I want to make is that mandated benefits should be thought of in the context of the minimum wage.

I know that your committee doesn't have jurisdiction over the minimum wage, but as Congressmen and social leaders, you can think of mandated health benefits in the context of minimum wage increases and welfare reform.

When you do this, you get to the issue that concerns me the most, which is the implications of new mandates on job opportunities, particularly for lower income and minority labor market entrants.

I think that some opponents of mandated benefits have embellished the costs and laid out wild scenarios of shocks to our economy that are probably unfair. What I tried to do in my testimony is to lay out some realistic estimates of what it would cost an employer if we were to pass something like the minimum wage bills currently pending very seriously before the Congress and mandated health benefits.

Under a range of assumptions, I estimated that these two steps would increase the cost of employing a low wage worker by between 50 and 72 percent. It is my view that increases of this magnitude cannot help but jeopardize job opportunities for labor force entrants, particularly our younger labor force entrants.

I think that it is unlikely, frankly, that mandated benefits would play havoc in a tremendous way with our trade deficit or cause a tremendous slowdown in growth. But I do think that it would cause some jobs that would have otherwise been offered to be withdrawn, and lead to some layoffs.

It would cause some people to be put to the back of the queue who are the most in need, and it doesn't get at the basic problem facing those entering the work force.

The basic problem is that many labor market entrants lack the skills, education and training to be qualified for jobs. I think that raising the cost of employing them through large increases in the minimum wage and health benefits could exacerbate that problem. Clearly, in the long run we have to improve their education and training so they can command a better pay package.

That is not to say we should do nothing until we improve the educational system in this country, but we have to be careful about piling on wage and benefit increases.

Let me suggest briefly some constructive alternatives to the mandated benefits approach and the minimum wage approach. Taken together, I think those changes could attenuate and limit the adverse side effects and, therefore, make this approach more attractive and less deleterious to the economy.

First of all, I think that we have a nice alternative to the proposed $4.55 minimum wage. If we were to raise it to $4 instead, and expand the earned income tax credit, as has been proposed by Congressman Petri and others, this, in a sense, would share between the Federal Government and the private sector the cost of raising the purchasing power of low-wage workers.

One of the things that concerns me, in fact, about mandated benefits is that the entire cost of solving this problem, which has been estimated by CBO at $27 billion for Senator Kennedy's bill, would be put on the private sector, on the private employer.

Chairman **Stark**. Let me go back. I am sorry, $27 billion was the cost of——

Mr. **Meyer**. CBO estimated that the cost of S. 1265, Senator Kennedy's mandated health benefits package, which is quite similar but not identical to your own, would be $27 billion.

Chairman **Stark**. That would cover roughly 27 million people, would it not?

Mr. **Meyer**. Close. About 24 million.

Chairman **Stark**. We were talking about 12 million people that would qualify for Medicare if Medicare was at the poverty level.

And they figured that would cost around $15 billion to add them in. I think we might suggest here that it is about $1 million per million people in any of these programs.

Mr. **Meyer**. I don't mean to suggest one approach costs a lot of money and one doesn't. Everything I advocate costs money, too. I want to be honest about it. One of the things that concerns me is some of the approaches I would take have less deleterious effects on job opportunities.

We have to worry about not only what benefits a job conveys, but also whether one holds a job. While you are bad off to have a job without health insurance, you are worse off to have no job and not qualify for medicaid.

We have some tradeoffs. It is not that one approach is bad and the other is good. I would suggest that the first step the Congress could take to deal with adverse side effects of proceeding in a mandated health benefits direction, is to ease up on raising the minimum wage.

I have suggested an interim position where the Government would expand the earned income tax credit through varying it by family size. In this way, the larger families would not be so discriminated against as they are today; they would receive real purchasing power equal to that offered to smaller families.

The Government would be saying to the private employer, "we will pay about half the cost and you pay about half the cost of restoring the purchasing power of the minimum wage."

Similarly, let me tick off a couple quick modifications in your proposal that I think would also improve its prospects, limit its adverse side effects, and represent a kind of sharing.

I worry about this 80/20 premium sharing provision in all the bills. I think that is perfectly appropriate for lower wage workers, but there are also a lot of American workers who are uninsured who could afford to pay more than 20 percent of the premium.

Perhaps we ought to make it 80/20 under some wage rate. The floor under the enployer's share should be lowered from 80 percent of the premium cost to 60 percent. I even suggest 50/50 split of the cost in my testimony. I think that permitting employers to pay less than 80 percent of the premium cost is preferable to raising the deductibles and copayments. It would concern me to keep the split at 80/20 and try to save money by raising deductibles which could discourage health service use. I would rather keep deductibles modest.

I also worry about tying mandated benefits to the Medicare package, as this legislation does. I think that could cause a lot of problems because we are directing this bill to the non-Medicare population.

And, if we are going to go down this road of mandated benefits, the Dukakis approach of offering the employer a choice of paying a tax into a fund or offering coverage is preferable to a simple mandate to offer coverage.

I think that is a more sensible approach and would bring some relief to employers. In fact, there are some phase-in and exemption provisions in the Massachusetts legislation that are responsive to the potential deleterious effects on workers.

So those are my comments. I really do applaud you for offering something that is up to the scale of the problem, instead of just chipping away at the margins.

I am not totally opposed to your proposal. I feel somewhat the way Mr. Reinhardt does, that if you tell me that this is the only thing we can do, I am receptive to it. I will still suggest a number of changes in it, but I feel obligated to say I think there are a few options out there that might be a little better.

Thank you.

[The statement of Mr. Meyer follows:]

STATEMENT OF JACK A. MEYER, PRESIDENT, NEW DIRECTIONS FOR POLICY

Mr. Chairman:

Thank you for the opportunity to testify before the committee on H.R.4951, a bill to provide minimum health care benefits for all employees in the United States working more than 17.5 hours per week.

This bill is addressed to a very serious problem. An estimated 35 - 37 million Americans have no health insurance, and many others have coverage that provides insufficient protection against catastrophic-level expenses of major illness. An estimated 24 million of the uninsured are either workers or their dependents.

I do not favor the mandated benefits approach incorporated into H.R. 4951 and other similar bills introduced in Congress. I will discuss the drawbacks of this approach below, but first I want to outline an alternative approach to the troubling problem of medical indigency.

I favor an approach based on either a universal federal income tax credit or a sliding scale voucher program in which government subsidies vary directly with the degree of financial need. The credits or the voucher payments would be set at a level permitting lower-income people to pay the premium for private group health insurance.

The tax credit plan, developed by Alain Enthoven of Stanford University, would correct some of the basic flaws in our present approach to medical indigency. For example, it would uncouple health care assistance from the vagaries of the AFDC cash assistance program, basing aid on need alone. It would promote a competitive health care market by arming the poor directly with fixed-dollar purchasing power that could be used for any qualified health plan. The value of the subsidy would vary with such factors as age and sex, and would be updated annually for inflation.

Under the voucher program, the government would make a payment on behalf of a low-income household to a private health plan such as Blue Cross, an HMO, a preferred provider plan, or a commercial insurance plan. As the beneficiary's income rose, his contribution to the premium would kick in, and the government premium subsidy would gradually phase out in the near-poor income range.

These approaches target government aid to the households that need it. By contrast, under a mandated benefit approach, government puts no money into the kitty and requires employers to help everyone, irrespective of the worker's ability to help himself. Everyone, that is, who is in a family with labor force attachment. Still left out in the cold under mandated benefits are low-income people without a worker in the household who do not qualify for Medicaid. Under the approach I favor, government does not pass the buck to the private sector, and aid is targeted to need, not labor market status.

One progressive way to fund the approach I favor would be to put a ceiling on the exclusion from taxable income by employees of the employer's contribution to health insurance. A cap of $225 a month on family policies and $90 a month on individual policies would yield an additional $47.5 billion in revenue over the 1989-93 period ($30.6 billion in income taxes and $16.9 billion in payroll taxes).

Interim steps toward such a new approach to government health policy for the poor could include the following:

o Establish a floor under AFDC benefits that would assure more of the poor access to the Medicaid program. For example, Medicaid covers only about half the poor children in the U.S. This floor would be set below the federal poverty line (e.g. the sum of AFDC and Food Stamps must equal two-thirds of the poverty line) to ensure that public assistance does not become relatively more attractive than wages in certain states. States would have to meet these minimums in order to obtain federal matching money under AFDC and Medicaid.

o Extend recent Congressional initiatives enabling the states to offer

Medicaid coverage to poor people who are not receiving cash assistance.

o Relax restrictive asset tests under the Supplemental Security Income (SSI) program and develop outreach efforts to increase participation in this program, which currently serves only about half the nation's elderly and disabled poor. By bringing more elderly and disabled poor into SSI, these reforms would make them eligible for Medicaid as well.

o Reform the Medicaid program, emphasizing greater reliance on case management, higher fees to attract providers to serve low-income patients, and risk sharing arrangements between government and doctors, hospitals, and other providers that facilitate the cost conscious use of health care resources.

Private Sector Initiatives

A number of private sector strategies can also be utilized to broaden insurance coverage without putting mandates on employers. These include using tax incentives, forming voluntary risk-pooling arrangements, allowing people to buy into government programs, and creating special high-risk pools for people for whom health insurance premiums would otherwise be out of reach.

o Extend health-related tax preferences to self-employed people and unincorporated businesses. I am pleased to see that the proposed legislation under consideration today includes a provision to foster equity among self-employed people and other members of the work force.

o Make greater use of risk-pooling arrangements that can lower premium costs by yielding administrative economies to both the insurer and the purchaser, as well as through obtaining more favorable underwriting terms available to larger groups. Again, H.R. 4951 does address this option of making greater use of risk pools.

o Promote Multi-Employer Trusts, or METs -- self-funded group benefit plans bringing together sole proprietorships, partnerships, etc. into a multi-employer group.

o Make greater use of state-sponsored high-risk pools for uninsured workers who cannot obtain coverage in the private insurance market because of pre-existing medical conditions.

o Allow the uninsured to buy into Medicaid coverage on a sliding scale basis, with their contributions to the premium depending on their incomes.

The Problem with Mandated Benefits

Flat mandates on employers to provide comprehensive health coverage will have adverse side effects, and workers will be the principal victims of those effects. Such mandates will be all the more problematical if they are accompanied by sizeable increases in the minimum wage and other mandates, such as guaranteeing workers a job during an extended leave of absence related to pregnancy.

The adverse side effects are likely to be felt most by lower-wage workers who are at or a little above the minimum wage. A fixed package of employee health benefits will be a relatively greater proportion of a low-wage worker's total compensation. For example, in a major metropolitan area, the premium for family coverage might be $250 per month. Suppose the employer paid 80 percent of the premium (this is the minimum employer share under the proposed bills), or $200 per month. In this example, the employer's share of the premium cost would be $1.20 per hour, or 30 percent of the earnings of a full-year worker earning $4.00 an hour, and 36 percent of the earnings of someone working full-year at the current minimum wage.

If the minimum wage were raised to $4.55 per hour (over three years), as is contemplated under proposed legislation, the total cost impact of the two steps --the wage increase and the family health policy --would be $2.40 per hour, or a 72 percent increase in the total labor cost of a worker receiving the minimum wage today. For such workers requiring only an individual health insurance policy, of course, the cost increase would be smaller. For example, an individual policy might cost $80 per month; if the employer paid 80 percent of the premium, the cost per hour would be about 38 cents, or 11.3 percent of the current minimum wage. In this case, total labor costs would rise by about 47 percent if both the full minimum wage increase and mandated benefits were enacted as currently proposed in the Congress.

By contrast, the cost increases associated with a combination of minimum wage and health benefit legislation for a worker earning $10 per hour would amount to only 12 percent. Such workers would not be affected by the minimum wage increase, and a $200 per month employer contribution to a health insurance policy would add 12 percent to the total cost of employing them ($1.20 per hour on a base of $10 per hour).

A summary of the proposed mandated benefits bill in the U.S. Senate uses estimates of premiums of $708 per year for an individual indemnity policy and $1,798 for a family policy, with a composite cost of $1,307. Under the assumption of an 80 percent contribution to the premium by the employer, the cost to the firm would be 52 cents per hour (Revised Summary of the Minimum Health Benefits for All Workers Act, 1988). When added to the full minimum wage increase to be phased in over three years, this would amount to an increase of $1.72 per hour in total labor costs, or a 51 percent jump in labor costs for a worker at the minimum wage today with no health insurance.

It is worth noting that some estimates of the cost of the mandated health benefits are higher than the ones presented to the Senate.

The cost of S. 1265 has been estimated at $27 billion a year by the Congressional Budget Office. If it were coupled with a significant increase in the minimum wage, the total cost would be much larger.

The effects on employment of the two measures could be significant. While the responsiveness of employment to the minimum wage is not huge, it has been shown to be in the range of 0.1 to 0.2 for teenagers -- i.e., a 10 percent increase in the minimum wage would reduce employment by 1 to 2 percent. If a health benefits mandate were enacted also, the combined effect on jobs would hurt teenagers and others entering the labor market.

The burden would fall most heavily on low-wage workers for whom the extra costs to employers of mandated increases in wages and benefits are proportionately highest. The majority of workers who keep their jobs will reap the gains from such mandates, but those who lose their jobs or cannot find one, will be the workers whose prospects for re-employment are most limited.

If a mandated benefits approach is adopted at the federal level, it should be modified in the following ways:

1. The required benefit package should be kept leaner, covering only "catastrophic" expenses. Employers could be encouraged but not required to offer additional coverage, perhaps by retaining the stop-loss limit of the current Senate bill ($3,000) but raising the maximum coinsurance that employees could be asked to pay below that limit from 20 percent to 50 percent. This is preferable to higher deductibles and copayments, even with the limited tax credit -- the approach taken in H.R. 4951.

2. It would be a mistake to model benefits after Medicare, as proposed in H.R. 4951, a bill to help the non-elderly.

3. The required number of hours that must be worked each week to come under the bill's purview could be raised from 17.5 to 25, to restrict its coverage primarily to full-time workers.

4. Temporary workers' eligibility for coverage should be based on total hours worked over a six-month period, rather than on a weekly hours test for each month; this change was recently incorporated into the revised Senate bill.

5. Employers should be given the choice of providing catastrophic coverage or paying an extra amount of FUTA tax for uncovered workers. Receipts from this tax would be pooled with state monies to extend catastrophic protection to these workers, who would be asked to contribute to the cost as well.

6. To the extent permitted by law, the federal mandate should be accompanied by a restriction on further mandates covering particular services or providers at the state and federal levels. In this way, broadening limited coverage under the federal mandate would substitute for deepening coverage under the piecemeal and uneven process of state-by-state mandating of benefits.

In addition, I would prefer an increase in the minimum wage to $4.00 an hour (instead of $4.55), coupled with an enhancement of the Earned Income Tax Credit. The latter could be accomplished by varying the EITC with family size to correct inequities among households in the real value of the credit. This combination of a $4.00 minimum wage and an EITC increase has been proposed by Congressman Petri.

These changes, as a package, should limit the adverse effects of federally-mandated benefits on job opportunities, and on the flexibility that employers need to manage labor costs and remain competitive.

Chairman **Stark**. Thank you.

Let me see, if there are around 37 million people who aren't participating, let's just say for a minute that costs $37 million. I am advised that in round, round figures, uncompensated care and bad debt runs $8 to $10 million and tax subsidies of public hospitals might run $5 to $10 million.

Let's say that 20 percent of that is being paid for by the system now. So we really are hanging out for about $17 billion, which—we could describe $15 billion to be Medicaid eligible, but that would break the States.

If you made every State come up to the poverty level, they would have to pay 45 percent of it and there are an awful lot of States who can't do that.

And we are really, at that point, just saying—almost half of this is being swallowed now by the system and the costs are being transferred.

We have got a $20 billion problem and we ought to solve it. Then the question is what is the fairest way to pay for it.

I don't think there is much of a quarrel about it.

Mr. **Meyer**. I agree with that logic. In fact, it may be more favorable to your case than is shown in the numbers you used. The last time I testified on this subject was over at Energy and Commerce last spring, on Congressman Waxman's proposal, and I happened to follow Nancy Gordon, who testified for CBO. This same dialog occurred, and they asked her, of the $27 billion price tag that you put on this bill, what fraction of that do you think employers are spending anyway through State taxes for Medicaid, Federal taxes and property taxes, bad debt and charity, and so on?

And her answer was that about $17 billion of the $27 billion was being paid directly or indirectly by employers. CBO had done some work. They admit it was a rough estimate, but they had tried to add up all the costs passed along to employers.

That would indicate that what is hanging out is $10 billion for the working part of the uninsured population. My best guess at what is left unaccounted for in the nonworking population, the people who don't have labor force attachment, is $5 to $10 billion.

The total cost is probably in the $15 to $20 billion range. My concern is that it is not a good way to start by saying that we are going to the private sector with the first half of that cost in a way that is not targeted to financial need.

We know that among the uninsured working population there are those who shouldn't have to be paying much, but there are also those who might be able to pay half the bill themselves.

At the same time it seems to me that your comment is right, going all the way up to the poverty line as a minimum requirement for the States under Medicaid would create problems.

The Federal Government ought to set some floor on Medicaid coverage below the poverty line, but still well above the levels of many low-benefit States. I think it is unconscionable to have Alabama providing an AFDC benefit of one-sixth of the Federal poverty line, with very poor people getting screened out of Medicaid as a result.

Cost estimates for what I advocate, a floor of two-thirds of the poverty line, for food stamps plus AFDC, which would sweep a lot of people into Medicaid, are about $3 to $4 billion. So what I am saying is there are, again, interim steps. I don't think we ought to put the entire poverty population on Medicaid anyway, as there are a lot of them working who could get into private plans if we create incentives for this.

My recommendations to this committee is, first of all, to look at mandated benefits in the context of welfare reform and the minimum wage, though some of that is outside your jurisdiction. Then you can say we have to do something about the problem, we want young kids to have job opportunities, yet we want people to have health coverage, so what would be a fair compromise? How could we have some Government incentives or mandates and welfare reform to take care of the problem?

Chairman STARK. The original Stark policy which fell on deaf ears to the Labor Committee, was to split the difference, instead of popping for a dollar and increasing the minimum wage, let's do 50 cents with mandated benefits, in fifties cash money, and then all of the seniors make hamburgers and all of the teenagers covered by their parents' plan would create a subminimum wage labor opportunity and the others would pay something we haven't established.

That never got off the ground. The other question is, you mentioned vouchers—is it a plan that says you will get hit with a tax but if you have got a receipt, you won't pay the tax?

Therefore, if you can't get insurance—one would presume that to work, that our Government benefits would be the benefits that are somewhat less generous than the standard plans available now, more in the nature of catastrophic than approaching the first dollar.

Do you have any problem with which way we could do that? Charge everyone and those who have it—give everyone a chip?

Mr. MEYER. No, I don't have a strong preference there. What I do have a strong preference on is something I think Congressman Gradison was getting at before. I have a preference for a kind of Government aid that is fixed dollar and doesn't ride up with the generosity of the health benefits package.

What he suggested, if I understand it, is a tax credit equal in value to a cost-effective plan. We are not going to have the Federal Government underwrite higher cost plans.

Chairman STARK. I have no quarrel with that, but I think we will get our cost savings when major industries come with us. Congress will not beat the AMA, but General Motors will. They don't get elected. They are going to get stuck with some doctors' fees. That is going to bring it into line.

Mr. MEYER. I think that is right, but I do feel the open-ended nature of the tax subsidy over the years has been one of the factors feeding the profligacy in the private sector. If you cap the subsidy, it would help contain costs, but opponents feel that a cap would lead to too much thriftiness.

The important point is that a lot of people today are left out. Congressman Gradison made the point that the current tax subsidy helps those with the most income and not those people who need it most. Whether you get health insurance depends on your labor market status. Under your proposal, a person gets help if he is one of the two-thirds of the uninsured in a household with labor force attachment, and he doesn't get it if he is in the other one-third, even if he is the most needy in terms of income.

Chairman **Stark**. That becomes the Medicaid expansion. I don't think this committee would ignore them or the fact that that is the only system I can see, or maybe we are starting over again like back in the early sixties, considering where we are now, those folks you have to show who are into medicare.

Mr. **Meyer**. That is reasonable. You have to start some place. I am not faulting you for starting where you are.

Mr. **Gradison**. Thank you, Mr. Chairman. Thank you for your testimony, Jack.

I think it is very unlikely that the Congress would mandate employer coverage without at the same time taking care of those who don't have jobs. I may be wrong, but if I am correct, then it is disingenuous to say it will not cost anything. It would have to cost something, as in the case of Massachusetts, where there is a substantial State cost involved, not for those mandated, but those who are not, those who work with new businesses with less than six employees, and those who don't have jobs at all.

The second point with regard to the Massachusetts plan on which I think it is fair to say the jury is still out, because it doesn't go into effect until 1992. It is that the pay or play approach may make many employers decide to pay. If there is a tax at the rate of 12 percent on the first $14,000 of wages, which will be $1,680 a year, many employers who don't have health insurance may decide it would be less expensive to let these folks be covered by the health plan than to have health insurance which probably costs more than $1,600 a year and certainly will be costing more than that by 1992.

They will be looking for a way to get out from under. They will let these folks go under the State pool, which requires a substantial amount of public subsidies, or they will try to get a change in the law which will discourage the employees from being under the State plan. I don't think one should necessarily assume that the way that threshold is designed will have a neutral effect on whether you play or you pay.

Finally, I want to thank you for putting the issue of mandated benefits in a larger context. I don't personally have any ideological hangups about mandated benefits. We have mandated some things and not others. I have found a tendency on those who support one set of mandated benefit to also support others such as mandated increases in severance pay, health care, day care.

The concern you expressed about adding up just two of these programs is something we should share. In a rational world, you sit down and say, health is so important that we are going to do something in the law, not only to require health coverage, but to indicate we are not going to touch any of these other things for the next 5 years. That is not the way the world works.

The inability to discriminate one mandated benefit against the other may in the end mean that none of them happens. I think that is highly regrettable, considering the way the employer-employee relationship can be used to expand some of these programs, not just in the health field.

Your comments are extremely helpful, as always. Those are some of the thoughts they generated in my mind. Thank you, Mr. Chairman.

Chairman STARK. Jack, thank you. As usual, your testimony was provocative. We look forward to your counsel in the next couple of years.

Mr. MEYER. Thank you.

Chairman STARK. Our next witnesses are a panel, including Deborah Chollet, Ph.D., senior research associate, Employee Benefit Research Institute; and E. Richard Brown, Ph.D., associate professor, School of Public Health, University of California at Los Angeles.

We welcome both of you to the committee. Without objection, we will make your prepared testimony part of the record in its entirety. We encourage you to expand on your testimony or present it in whatever fashion you feel comfortable.

STATEMENT OF DEBORAH J. CHOLLET, PH.D., SENIOR RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Ms. CHOLLET. Good morning. Since I have not before had the opportunity to testify before this subcommittee, I would like to mention that the Employee Benefit Research Institute is a nonpartisan public policy research organization: we do not take positions on public policy issues.

I was asked to provide for you this morning a summary description of the population without health insurance in the United States. I am pleased to do so, with the caveat that the uninsured population is very heterogeneous: no one or two simple categories adequately describes who lacks health insurance. However, there are some classifications of the uninsured that, I believe, suggest where some of the gaps in our system of health insurance occur. There are many ways to begin to close those gaps that would be more or less successful and more or less expensive for government, workers, employers, and health care providers; others testifying today have already addressed some of those options.

The data that I will be using to describe the uninsured are Census data from the March 1987 Current Population Survey. These data describe coverage and noncoverage during late 1986 and early 1987.

As you are aware, about 37 million Americans are without health insurance: that is, they do not have private insurance coverage from either an employer plan or an individual insurance plan, and they do not qualify for Medicaid or Medicare. In 1986, these people totalled nearly 18 percent of the civilian population under age 65.

This proportion is approximately equal to that reported in 1984 and 1985, but it is substantially higher than the proportion of the population without health insurance at the beginning of the decade. In 1982, less than 16 percent of the population was uninsured. The difference in these rates means that, in 1986, there were about 6 million more people without health insurance than there were in 1982.

Nearly half of the uninsured population in 1986 (48 percent) were workers; one-third of the uninsured were children under age 18. Most of the uninsured population in 1986—nearly 88 percent—either worked or lived in a family headed by a worker.

Most of these workers were full-time, full-year workers that experienced no unemployment that year. In all, about half of the uninsured population lived in families headed by a full-year, full-time, steadily employed worker.

About 40 percent of the uninsured population lived in families headed by workers in other categories: that is, families headed by a full-year worker who was unemployed some time that year, or families headed by a part-time or part-year worker.

While three-quarters of all workers had health insurance from an employer plan in 1986, uninsured workers obviously did not. Workers without insurance from an employer plan can be profiled: they tend to have different characteristics than workers that obtain health insurance as an employee benefit. In particular, workers without coverage are likely to be lower wage, relatively young, and/or short-tenure workers.

In 1986, 74 percent of workers without health insurance earned less than $10,000 that year. Half were under age 30. From preliminary analysis of other Census data, we know that about half of uninsured workers have been in their current job for 1 year or less. In fact, many workers with these characteristics—young, short-tenure, low wage—when they are insured by an employer plan are not covered as a benefit of their own employment. Rather, they are covered as a dependent under another worker's employer plan.

I would like to finish my testimony by talking briefly about one particular group of the uninsured, children and families with children, since these families pose special concerns for public policy. Families with children under the age of 18 represent about 60 percent of the uninsured population in the United States.

In 1986, children were more likely than adults to be uninsured: 19 percent of all children in the United States under the age of 18 were uninsured. Among children living in poor or near-poor families (that is, families with income below 125 percent of the Federal poverty standard), 35 percent—more than 1 in 3—were uninsured.

It is ironic that, among all low-income families with children in this country, the families that are least likely to have health insurance are headed by full-year workers. In 1986, nearly 40 percent of people in two-parent, low-income families with children were uninsured when they were headed by a full-year worker; when the family was headed by a single parent that worked all year, nearly one-half (46 percent) were uninsured. People in these families, low-income families with children headed by a full-year worker, were about twice as likely to be uninsured as people in low-income families headed by someone who didn't work at all.

In 1986, 20 percent of the uninsured population were in families of, if you will, the working poor: low-income families headed by a full-year worker. The relatively high rate of noncoverage among these families reflects State Medicaid provisions that disqualify categorically eligible families from coverage at incomes below the federal poverty standard, and below the earnings of most low-wage workers; as well as low rates of employer coverage among these workers.

Not all children, even children in low-income families, are equally likely to be uninsured. In 1986, the children least likely to have health insurance were either infants (under 1 year of age) or adolescents (age 13–17). In families with income below the Federal poverty standard, 40 percent of infants under one year were uninsured; among infants in near-poor families, 38 percent were uninsured. In both poor and near-poor families, about the same proportion of adolescents, 41 percent, were uninsured.

Legislation passed earlier this year requires States to provide Medicaid coverage to pregnant women and infants in families with income below poverty. While this legislation will assist some of these children—infants in poor families—it does not address the high rate of noncoverage among near-poor infants or older children in low-income families. In 1986, these children in poor and near-poor families not specifically addressed in current law represented nearly half of all children without insurance coverage.

My written testimony refers to other population groups that show particularly high rates of noncoverage: farm families, and families in specific states where the employer coverage rate and/or the Medicaid coverage rate is relatively low. In three States—Mississippi, New Mexico and Texas—more than one-quarter of the total population is uninsured. I would direct you to the tables and figures in my written statement for a fuller description of these uninsured groups, as well as the other groups that I've described this morning.

Thank you for the opportunity to appear before you today. There are many ways to begin forging a private/public partnership to address the needs of the uninsured population. I would be pleased to assist the committee in any way possible as you continue your deliberations in this area.

[The statement of Ms. Chollet follows:]

EBRI

T-67

U.S. House Committee on Ways and Means
Subcommittee on Health
Hearing on the Uninsured
September 22, 1988

Testimony of

Deborah J. Chollet, Ph.D.
Senior Research Associate

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In 1986, nearly 18 percent of the civilian population under age 65 reported no health insurance coverage from any source.[1] These people totaled 37 million in number. The proportion of the population reporting no health insurance in 1986 was approximately the same as that without health insurance in 1984 and 1985, but substantially greater than the percentage that reported no health insurance in the early 1980s. In 1982, less than 16 percent of the nonelderly civilian population were uninsured.

Who are the uninsured?

In 1986, nearly one-half of the uninsured (49 percent, or 18.1 million people) were workers. Another one-third (33 percent, or 12.2 million people) were children under age 18. Only 18 percent of the uninsured (6.7 million people) were nonworking adults.

Nearly 88 percent of the uninsured population were either themselves workers or lived in families of workers. For about one-half of the uninsured, either the uninsured individual or their family head was a full-time, full-year worker (that is, a worker who worked or sought work at least 35 weeks in 1986 and worked at least 35 hours in a typical week) and reported no unemployment during the year. In 1986, nearly half of the uninsured population (47.8 percent, or 18 million people) lived in families of such workers: full-time, full-year and steadily employed. Another 22 percent of the uninsured population (8.2 million people) lived in families of full-year workers who reported one or more weeks of unemployment during the year. About 18 percent of the uninsured population (6.5 million people) lived in families where the family head was either a part-year worker (for example, a seasonal worker) or a part-time worker. Twelve percent lived in nonworker families.

Economic and family status of the uninsured

The uninsured population live predominantly, but not exclusively, in low and middle-income families. About one-half of the uninsured population (50.5 percent) reported family income of less than $15,000 in 1986; more than three-quarters (77.2 percent) reported family income of less than $30,000. However, nearly 14 percent of the uninsured reported family income that exceeded $40,000 in 1986.

About one-third of the uninsured population (32.1 percent, or 11.9 million people) reported family income (adjusted for family size) below the federal poverty standard. Nearly one-half (48.9 percent) reported family income that was less than 150 percent of the poverty standard. In 1986, the federal poverty standard for a family of four was $11,203.

In 1986, more than one-half of the uninsured population (58.7 percent) lived in families with children; one-quarter lived in single-parent families with children. Among the uninsured poor or near-poor population (with family income less than 125 percent of the poverty standard), two-thirds (67.9 percent) lived in families with children; more than one-third (36.3 percent) lived in single-parent families with children. About one-quarter of the uninsured (25.3 percent) were single adults without children.

The rate of noncoverage among some family types in particular economic situations is especially high, even though these family types may not represent most of the uninsured. For example, among people living in single-parent families with children in 1986, nearly one-third (30.1 percent) were uninsured, compared to less than 13 percent among two-parent families with children. In part, this high rate of noncoverage reflects the predominantly low incomes of single-parent families.

Among low-income families, however, single-parent families are somewhat more likely than two-parent families to be insured, principally because of better access to Medicaid. In 1986, 38 percent of poor and near poor people in two-parent families with children were uninsured (compared to 32.5 percent of those in single-parent families). The relatively high rate of noncoverage among families of the working poor reflect state Medicaid provisions that disqualify categorically eligible families from coverage at incomes below that earned by many low-wage workers. Among people in poor or near-poor families with children, people were most likely to be uninsured (46.3 percent in single-parent families, and 39.8 percent in two-parent families) if the family head was a full-year worker.

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[1] The data presented here are not strictly comparable to those that EBRI published in 1987. These data include agricultural workers and their families, but exclude all people living in families of military personnel; the 1987 publication excluded both groups.

The relatively high rate of noncoverage among poor and near-poor families with children also appears in the rates of noncoverage among children themselves, and especially among infants and adolescents. In 1986, 19 percent of all children in the United States were uninsured. Among children in poor families, 34 percent were uninsured, while among children in near-poor families, nearly 37 percent were uninsured. Among infants in poor or near-poor families -- children younger than one year, 38 percent were uninsured, while among adolescents (age 13 to 17), 40 percent were uninsured. Recent legislation amending Title XIX of the Social Security Act may improve the rate of coverage among infants in poor families as it becomes effective. However, the legislation does not address noncoverage among infants in near-poor families and among adolescents in both poor and near-poor families.

The rate of noncoverage among poor or near-poor families without children is especially high. In 1986, 45 percent of poor or near-poor married people without children had no insurance from any source; where at least one family member was a full-year worker, one-half had no insurance. Among poor or near-poor single adults without children, nearly 52 percent were uninsured; among those who were full-year workers, 57 percent were uninsured.

Noncoverage within states: urban and rural areas

Rates of noncoverage across the country differ significantly among the states, largely as a consequence of differences in employer coverage and Medicaid eligibility. In 14 states[2] and the District of Columbia, more than 20 percent of the nonelderly population were uninsured in 1986. In Mississippi, New Mexico and Texas, more than one-quarter of the nonelderly population were uninsured.

In general, the rural population in the United States is less likely to have health insurance than the urban population. In 1986, 17.4 percent of the urban population (and suburban) were uninsured, compared to 19.1 percent of the rural population. Among the rural population, agricultural workers and members of their families report especially high rates of noncoverage, despite relatively high rates of individual insurance purchase: nearly 32 percent of agricultural workers and their families were uninsured in 1986. Among the agricultural population in poverty, nearly 49 percent were uninsured.

Noncoverage among workers

Employer plans are the predominant source of health insurance among workers and their families. In 1986, nearly three-quarters of all workers (74.7 percent, or 88.1 million workers) were covered by an employer health insurance plan. However, 15.4 percent of workers reported having no health insurance from any source.

Most uninsured workers in 1986 (59.9 percent) were full-year, full-time workers; that is, they worked or sought work 35 weeks or more in 1986 and worked at least 35 hours in a typical week. Other uninsured workers were approximately evenly divided between part-year workers (including seasonal workers) and part-time workers.

In general, young workers are substantially less likely than older workers to have insurance coverage, either from an employer plan or from any other source. This may be the result of relatively frequent job change among younger workers and the relative likelihood that they work in low-wage jobs. In 1986, 58 percent of workers age 21 to 24 were covered by an employer plan; nearly one-quarter (24.4 percent) had no health insurance from any source. By comparison, nearly 88 percent of workers age 45-54 had employer coverage, and only 10 percent reported having no health insurance from any source.

Most uninsured workers earn relatively little on their jobs. In 1986, nearly three-quarters of uninsured workers (73.6 percent) earned less than $10,000 that year; 34 percent earned less than the federal minimum wage. Nearly all (92.3 percent) earned less than $20,000. Among workers that earned less than $10,000 in 1986, 29 percent were uninsured.

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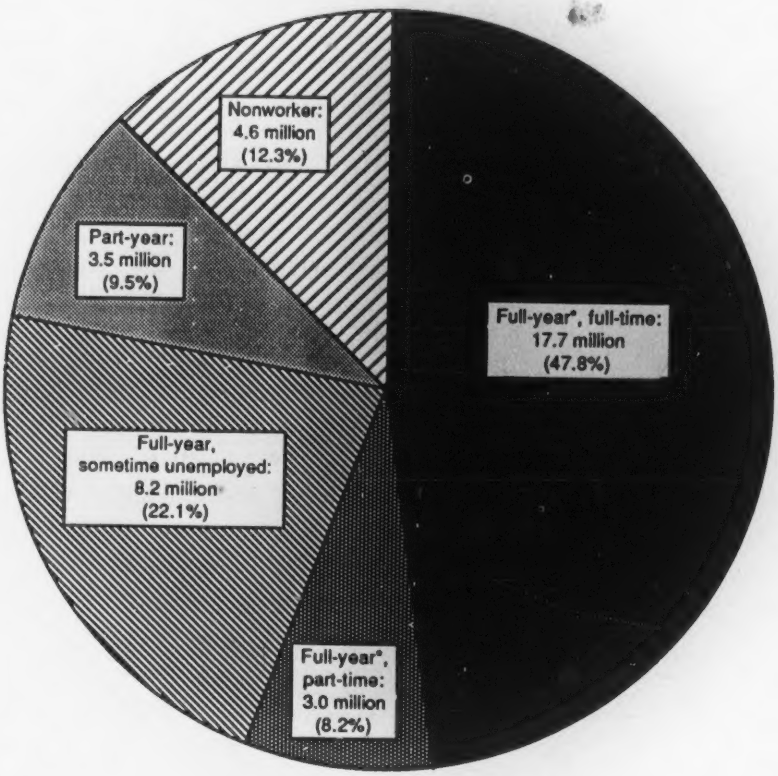
[2] Alabama, Alaska, Arizona, Arkansas, California, Florida, Idaho, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, Tennessee and Texas.

Nonelderly Population by Selected Sources of Health Insurance and Own Work Status, 1986

Own Work Status	Total	Private Coverage					Public Coverage		No Health Insurance Coverage
		Total Private	Employer-provided			Other Private			
			Total	Direct	Indirect		Total	Medicaid	
Total	208.0	152.9	136.1	70.2	65.9	23.8	24.9	17.0	37.0
Family Head Workers	73.1	59.9	54.9	52.8	2.1	8.2	4.6	2.3	10.9
Other Family Workers	44.2	36.2	33.0	17.3	15.7	4.9	2.0	0.7	7.2
Other Nonworkers	28.5	15.0	9.7	a	9.7	6.0	8.6	5.5	6.7
Children	62.1	41.8	38.5	0.1	38.4	4.8	9.8	8.5	12.2
				(percent within worker categories)					
Total	100.0%	73.5%	65.4%	33.8%	31.7%	11.5%	12.0%	8.2%	17.8%
Family Head Workers	100.0	81.9	75.1	72.2	2.8	11.1	6.2	3.2	14.9
Other Family Workers	100.0	81.8	74.7	39.1	35.5	11.2	4.4	1.6	16.3
Other Nonworkers	100.0	52.7	34.1	a	34.1	20.9	30.1	19.4	23.5
Children	100.0	67.3	61.9	0.2	61.7	7.7	15.8	13.6	19.7
				(percent within source of coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Family Head Workers	35.2	39.2	40.3	75.2	3.2	34.2	18.3	13.6	29.5
Other Family Workers	21.3	23.7	24.3	24.6	23.9	20.7	7.9	4.1	19.4
Other Nonworkers	13.7	9.8	7.1	a	14.8	25.0	34.4	32.5	18.1
Children	29.9	27.3	28.3	0.1	58.2	20.1	39.4	49.8	33.0

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
a--Number is too small to be statistically reliable.

Nonelderly Population Without Health Insurance by Employment Status of Family Head, 1986



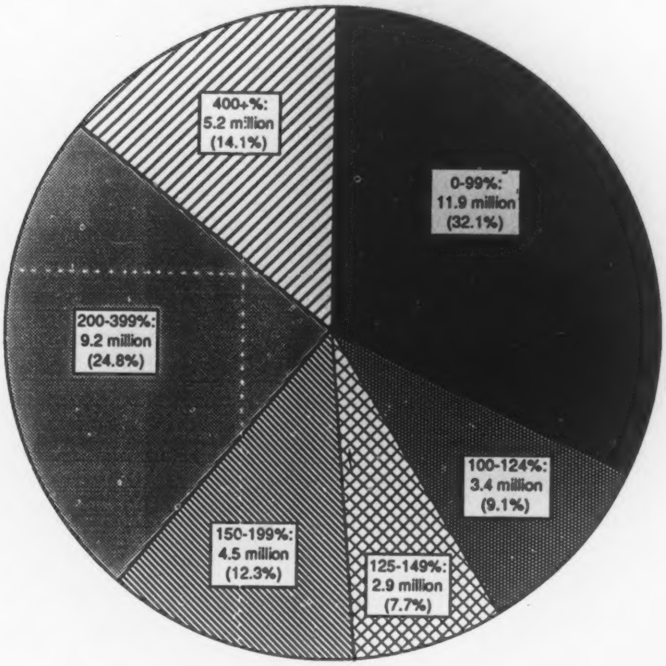
Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
*Never unemployed at any time during the last year.

Nonelderly Population by Selected Sources of Health Insurance and Family Income, 1986

Family Income	Total	Insured Population: Private & Public							No Health Insurance Coverage
				Employer-provided			Public		
		Total	Total Private	Total	Direct	Indirect	Total	Medicaid	
				(in millions)					
Total	208.0	191.0	152.9	136.1	70.2	65.9	24.9	17.0	37.0
Under $5,000	15.2	8.7	2.5	1.0	0.6	0.4	6.8	6.4	6.2
$5,000-$9,999	17.1	11.4	5.0	3.2	2.1	1.1	6.5	5.8	6.3
$10,000-$14,999	18.5	16.3	10.1	7.9	4.8	3.1	3.1	2.2	6.2
$15,000-$19,999	18.3	17.3	13.0	11.0	6.1	4.9	1.7	1.0	4.3
$20,000-$29,999	37.8	36.9	31.0	27.6	14.0	13.6	2.5	0.9	5.6
$30,000-$39,999	34.2	33.8	30.4	28.0	13.6	14.4	1.6	0.4	3.3
$40,000 or More	66.9	66.6	61.1	57.4	29.0	28.4	2.5	0.3	5.1
				(percents within income groups)					
Total	100.0%	91.8%	73.5%	65.4%	33.8%	31.7%	12.0%	8.2%	17.8%
Under $5,000	100.0	57.5	16.4	6.6	4.2	2.3	45.0	42.5	40.9
$5,000-$9,999	100.0	66.4	29.0	18.9	12.3	6.7	38.0	33.6	36.9
$10,000-$14,999	100.0	88.0	54.3	42.9	26.1	16.9	17.0	12.0	33.4
$15,000-$19,999	100.0	94.7	70.9	59.9	33.2	26.7	9.5	5.3	23.3
$20,000-$29,999	100.0	97.5	82.0	73.0	36.9	36.1	6.7	2.5	14.9
$30,000-$39,999	100.0	98.9	88.7	81.7	39.7	42.0	4.7	1.1	9.6
$40,000 or More	100.0	99.6	91.3	85.9	43.4	42.4	3.8	0.4	7.7
				(percents within source of coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under $5,000	7.3	4.6	1.6	0.7	0.9	0.5	27.4	37.9	16.7
$5,000-$9,999	8.2	6.0	3.3	2.4	3.0	1.7	26.2	33.9	17.1
$10,000-$14,999	8.9	8.5	6.6	5.8	6.9	4.7	12.6	13.1	16.7
$15,000-$19,999	8.8	9.1	8.5	8.1	8.7	7.4	7.0	5.7	11.5
$20,000-$29,999	18.2	19.3	20.3	20.3	19.9	20.7	10.2	5.5	15.2
$30,000-$39,999	16.5	17.7	19.9	20.5	19.4	21.8	6.5	2.3	8.9
$40,000 or More	32.2	34.9	39.9	42.2	41.3	43.1	10.1	1.5	13.9

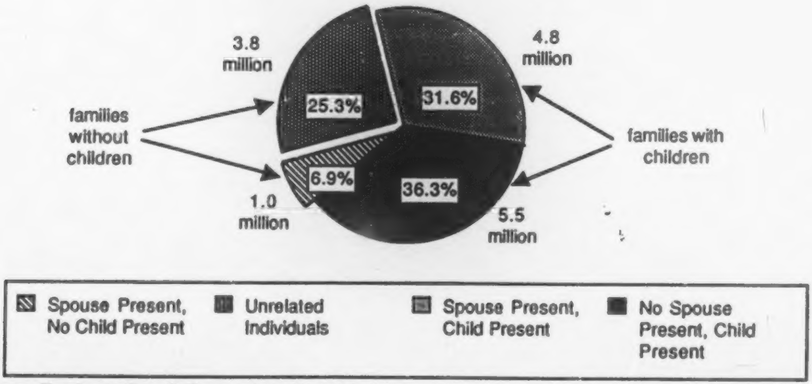
Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Nonelderly Population Without Health Insurance by Family Income as a Percent of Poverty, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Poor and Near Poor* Nonelderly Population Without Health Insurance by Family Status, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
*Family income is 0-124% of poverty.

Nonelderly Population by Selected Sources of Health Insurance, Family Type, Family Head's Employment Status and Family Poverty Status, 1996

Family Type and Employment Status of Family Head	Total	Insured Population: Private & Public								No Health Insurance Coverage
		Total	Total Private	Employer-provided			Public			
				Total	Direct	Indirect	Total	Medicaid		
	(in millions)									
	Total Population									
Total	208.0	171.0	152.9	136.1	70.2	65.9	24.9	17.0		37.0
Child Present										
Spouse Present	99.1	86.6	82.5	77.4	26.6	50.8	6.9	4.2		12.4
Full-year worker	94.8	83.6	81.0	76.4	26.3	50.1	5.1	2.8		11.2
Part-year worker	2.5	1.8	1.3	0.9	0.3	0.6	0.6	0.5		0.7
Nonworker	1.8	1.3	0.2	a	a	a	1.2	1.0		0.5
No Spouse Present	31.0	21.7	12.1	10.0	5.2	4.8	10.5	9.9		9.3
Full-year worker	19.1	12.8	10.7	9.4	4.9	4.5	2.8	2.4		6.3
Part-year worker	3.9	2.6	1.1	0.6	0.3	0.3	1.7	1.6		1.3
Nonworker	8.0	6.3	0.4	a	a	a	6.1	5.9		1.7
No Child Present										
Spouse Present	42.3	36.6	35.1	30.0	20.3	9.7	3.6	0.7		5.6
Full-year worker	37.2	32.7	32.0	29.1	19.8	9.3	2.3	0.3		4.5
Part-year worker	1.8	1.4	1.3	0.6	0.5	0.3	0.2	a		0.4
Nonworker	3.3	2.5	1.9	a	a	a	1.1	0.3		0.8
No Spouse Present	35.7	26.0	23.1	18.8	18.2	0.6	3.8	2.1		9.7
Full-year worker	28.9	21.9	20.9	18.2	17.6	0.6	1.7	0.7		6.9
Part-year worker	2.5	1.4	1.2	0.6	0.6	a	0.3	0.2		1.1
Nonworker	4.3	2.7	1.0	a	a	a	1.8	1.2		1.7
	Poor and Near-Poor Population (0-125% of Poverty)									
Total	39.6	24.3	10.6	7.1	3.1	4.0	15.2	14.0		15.2
Child Present										
Spouse Present	12.7	7.9	5.1	4.1	1.1	2.9	3.3	3.0		4.8
Full-year worker	10.3	6.2	4.7	3.9	1.1	2.8	1.9	1.8		4.1
Part-year worker	1.0	0.6	0.3	0.2	a	0.1	0.4	0.3		0.4
Nonworker	1.5	1.1	0.1	a	a	a	1.0	0.9		0.3
No Spouse Present	17.0	11.5	2.7	1.8	0.9	1.0	9.4	9.2		5.5
Full-year worker	6.3	3.4	1.9	1.6	0.7	0.8	1.9	1.7		2.9
Part-year worker	3.0	1.9	0.5	0.3	0.1	0.1	1.6	1.5		1.1
Nonworker	7.7	6.1	0.3	a	a	a	6.0	5.9		1.6
No Child Present										
Spouse Present	2.3	1.3	0.9	0.3	0.2	0.1	0.5	0.3		1.0
Full-year worker	1.1	0.5	0.5	0.3	0.2	0.1	0.1	a		0.5
Part-year worker	0.3	0.2	0.1	a	a	a	a	a		0.1
Nonworker	1.0	0.6	0.3	a	a	a	0.4	0.2		0.4
No Spouse Present	7.5	3.6	1.9	0.9	0.9	a	1.9	1.5		3.9
Full-year worker	3.3	1.4	1.1	0.7	0.7	a	0.4	0.3		1.9
Part-year worker	1.3	0.6	0.4	0.2	0.2	a	0.2	0.2		0.7
Nonworker	3.0	1.6	0.4	a	a	a	1.3	1.0		1.3

a–Number is too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance, Family Type, Family Head's Employment Status and Family Poverty Status, 1986 (Continued)

Family Type and Employment Status of Family Head		Insured Population: Private & Public							No Health Insurance Coverage
			Total	Employer-provided			Public		
	Total	Total	Private	Total	Direct	Indirect	Total	Medicaid	
				(Percent within coverage group)					
				Total Population					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Child Present									
Spouse Present	47.6	50.7	54.0	56.8	37.9	77.1	27.9	25.0	33.5
Full-year worker	45.6	48.9	53.0	56.1	37.4	76.1	20.6	16.4	30.3
Part-year worker	1.2	1.0	0.9	0.7	0.5	0.9	2.5	2.8	2.0
Nonworker	0.9	0.8	0.1	a	a	a	4.7	5.8	1.3
No Spouse Present	14.9	12.7	7.9	7.3	7.4	7.3	42.4	58.3	25.2
Full-year worker	9.2	7.5	7.0	6.9	7.0	6.8	11.2	13.9	17.1
Part-year worker	1.9	1.5	0.7	0.4	0.4	0.5	6.8	9.4	3.6
Nonworker	3.8	3.7	0.3	a	a	a	24.3	35.0	4.5
No Child Present									
Spouse Present	20.3	21.4	23.0	22.0	28.9	14.7	14.4	4.3	15.2
Full-year worker	17.9	19.1	20.9	21.4	28.1	14.2	9.1	2.0	12.1
Part-year worker	0.9	0.8	0.8	0.6	0.7	0.5	0.9	a	1.0
Nonworker	1.6	1.5	1.2	a	a	a	4.3	2.0	2.1
No Spouse Present	17.2	15.2	15.1	13.8	25.9	1.0	15.4	12.4	26.1
Full-year worker	13.9	12.8	13.7	13.4	25.0	0.9	6.7	4.2	18.8
Part-year worker	1.2	0.8	0.8	0.5	0.9	a	1.3	1.1	2.9
Nonworker	2.1	1.6	0.7	a	a	a	7.4	7.0	4.5
				Poor and Near-Poor Population (0-125% of poverty)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Child Present									
Spouse Present	32.2	32.6	48.4	56.9	36.8	72.3	22.0	21.7	31.6
Full-year worker	26.0	25.4	44.4	54.2	34.8	69.1	12.8	12.5	26.9
Part-year worker	2.5	2.5	2.8	2.6	a	3.0	2.5	2.4	2.5
Nonworker	3.7	4.6	1.1	a	a	a	6.8	6.7	2.2
No Spouse Present	43.0	47.2	25.4	25.9	28.1	24.2	62.2	65.6	36.3
Full-year worker	16.0	14.0	17.8	22.1	23.8	20.7	12.3	12.4	19.2
Part-year worker	7.6	8.0	4.8	3.8	4.3	3.5	10.5	10.9	6.9
Nonworker	19.4	25.2	2.8	a	a	a	39.4	42.2	10.2
No Child Present									
Spouse Present	5.9	5.4	8.3	4.4	6.4	2.9	3.3	2.2	6.9
Full-year worker	2.8	2.3	4.4	3.6	5.1	2.5	0.6	a	3.6
Part-year worker	0.7	0.6	1.1	a	a	a	a	a	0.9
Nonworker	2.5	2.5	2.9	a	a	a	2.3	1.5	2.4
No Spouse Present	18.9	14.9	17.9	12.8	28.7	a	12.4	10.6	25.3
Full-year worker	8.3	5.8	10.1	9.8	21.9	a	2.6	2.2	12.3
Part-year worker	3.2	2.5	4.0	2.9	6.7	a	1.3	1.1	4.3
Nonworker	7.5	6.7	3.8	a	a	a	8.5	7.3	8.8

a--Number is too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance, Family Type, Family Head's Employment Status and Family Poverty Status, 1986
(Continued)

Family Type and Employment Status of Family Head	Total	Insured Population: Private & Public							No Health Insurance Coverage
			Total	Employer-provided			Public		
		Total	Private	Total	Direct	Indirect	Total	Medicaid	
		(Percent within family type/employment group)							
		Total Population							
Total	100.0%	82.2%	73.5%	65.4%	33.8%	31.7%	12.0%	8.2%	17.8%
Child Present									
Spouse Present	100.0	87.5	83.3	78.1	26.8	51.3	7.0	4.3	12.5
Full-year worker	100.0	88.2	85.5	80.6	27.7	52.9	5.4	2.9	11.8
Part-year worker	100.0	70.4	53.9	38.0	13.0	25.0	25.2	18.9	29.6
Nonworker	100.0	74.1	11.9	a	a	a	64.9	54.7	25.9
No Spouse Present	100.0	69.9	39.2	32.2	16.7	15.5	34.0	31.9	30.1
Full-year worker	100.0	67.0	55.8	49.0	25.6	23.4	14.6	12.4	33.0
Part-year worker	100.0	65.6	27.2	15.3	7.1	8.2	43.7	41.0	34.4
Nonworker	100.0	79.0	5.0	a	a	a	75.9	74.5	21.0
No Child Present									
Spouse Present	100.0	86.7	83.2	70.9	48.0	22.9	8.5	1.7	13.3
Full-year worker	100.0	88.0	86.0	78.2	53.1	25.1	6.1	0.9	12.0
Part-year worker	100.0	78.4	72.4	47.7	28.6	19.1	13.3	a	21.6
Nonworker	100.0	77.0	56.7	a	a	a	32.3	10.4	23.0
No Spouse Present	100.0	72.9	64.7	52.8	51.0	1.8	10.7	5.9	27.1
Full-year worker	100.0	76.0	72.3	63.0	60.9	2.1	5.8	2.5	24.0
Part-year worker	100.0	57.0	46.7	25.6	24.3	a	12.9	7.7	43.0
Nonworker	100.0	61.7	24.1	a	a	a	42.4	27.6	38.3
		Poor and Near-Poor Population (0-125% of poverty)							
Total	100.0%	61.5%	26.7%	18.1%	7.8%	10.2%	38.3%	35.3%	38.5%
Child Present									
Spouse Present	100.0	62.2	40.2	32.0	9.0	23.0	26.3	23.8	37.8
Full-year worker	100.0	60.2	45.7	37.7	10.5	27.2	18.9	17.0	39.8
Part-year worker	100.0	61.4	30.4	18.4	a	12.3	37.5	33.7	38.6
Nonworker	100.0	77.0	8.0	a	a	a	70.8	64.5	23.0
No Spouse Present	100.0	67.5	15.8	10.9	5.1	5.8	55.5	53.9	32.5
Full-year worker	100.0	53.7	29.8	24.9	11.7	13.3	29.5	27.4	46.3
Part-year worker	100.0	64.8	17.0	9.1	4.4	4.7	53.3	51.1	35.2
Nonworker	100.0	79.8	3.9	a	a	a	77.8	76.8	20.2
No Child Present									
Spouse Present	100.0	55.4	37.5	13.5	8.5	5.0	21.3	13.0	44.6
Full-year worker	100.0	50.0	42.6	23.7	14.4	9.3	8.8	a	50.0
Part-year worker	100.0	53.8	40.0	a	a	a	a	a	46.2
Nonworker	100.0	62.1	31.2	a	a	a	36.6	21.9	37.9
No Spouse Present	100.0	48.5	25.3	12.2	11.9	a	25.1	19.8	51.5
Full-year worker	100.0	43.0	32.6	21.4	20.8	a	11.8	9.5	57.0
Part-year worker	100.0	48.1	34.1	16.8	16.6	a	16.2	12.1	51.9
Nonworker	100.0	54.9	13.5	a	a	a	43.6	34.4	45.1

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
a–Number is too small to be statistically reliable.

Children Under Age 18 by Selected Sources of Health Insurance Coverage, Age, and Family Poverty Status, 1986

Age and Poverty Status	Total	Private Coverage			Public Coverage		No Health Insurance Coverage
		Total Private	Employer Sponsored	Other Private	Total	Medicaid	
				(million)			
All Children							
Total	62.1	41.8	38.5	4.8	9.8	8.5	12.2
Infants	3.6	2.3	2.1	0.2	0.7	0.6	0.8
Age 1-5	17.7	11.9	11.0	1.2	3.1	2.8	3.2
Age 6-12	23.3	15.6	14.5	1.7	3.7	3.3	4.6
Age 13-17	17.5	12.1	10.9	1.7	2.3	1.8	3.6
0-99 % of Poverty							
Total	14.1	2.3	1.5	0.8	7.2	7.0	5.0
Infants	1.0	0.1	a	a	0.5	0.5	0.4
Age 1-5	4.5	0.8	0.5	0.2	2.5	2.4	1.4
Age 6-12	5.3	0.8	0.6	0.3	2.8	2.7	1.9
Age 13-17	3.2	0.6	0.3	0.3	1.5	1.4	1.3
100-124 % of Poverty							
Total	3.3	1.7	1.5	0.3	0.6	0.5	1.2
Infants	0.2	0.1	0.1	a	a	a	0.1
Age 1-5	1.0	0.5	0.4	a	0.2	0.1	0.4
Age 6-12	1.3	0.7	0.6	0.1	0.2	0.2	0.4
Age 13-17	0.9	0.4	0.3	a	0.2	0.1	0.4
125+% of Poverty							
Total	44.8	37.8	35.5	3.7	2.0	1.0	6.0
Infants	2.5	2.0	1.9	0.2	0.1	0.1	0.4
Age 1-5	12.2	10.6	10.0	0.9	0.5	0.3	1.4
Age 6-12	16.7	14.1	13.3	1.3	0.7	0.4	2.3
Age 13-17	13.4	11.1	10.2	1.3	0.7	0.3	1.9
				(percent within age groups)			
All Children							
Total	100.0%	67.3%	61.9%	7.7%	15.8%	13.6%	19.7%
Infants	100.0	62.4	57.7	6.8	18.0	16.1	22.8
Age 1-5	100.0	66.9	62.2	6.6	17.6	16.0	18.0
Age 6-12	100.0	66.9	62.0	7.3	15.8	14.0	19.8
Age 13-17	100.0	69.2	62.4	9.5	13.4	10.2	20.5
0-99 % of Poverty							
Total	100.0	16.4	10.9	5.8	51.2	49.9	35.7
Infants	100.0	13.2	a	a	50.7	49.5	39.9
Age 1-5	100.0	16.9	12.1	5.0	55.0	53.7	31.6
Age 6-12	100.0	15.5	10.6	5.2	51.9	50.9	35.6
Age 13-17	100.0	18.2	10.4		45.1	43.1	40.5
100-124 % of Poverty							
Total	100.0	50.8	44.2	8.3	17.1	14.9	36.8
Infants	100.0	49.9	41.6	a	a	a	37.6
Age 1-5	100.0	51.9	46.7	a	15.7	14.1	37.4
Age 6-12	100.0	53.4	46.5	8.7	17.4	15.7	33.7
Age 13-17	100.0	45.9	38.4	a	17.7	14.1	40.7
125+% of Poverty							
Total	100.0	84.5	79.2	8.3	4.5	2.1	13.4
Infants	100.0	83.1	78.6	7.4	4.8	2.7	14.9
Age 1-5	100.0	86.5	81.9	7.2	4.0	2.2	11.5
Age 6-12	100.0	84.3	79.5	7.9	4.2	2.1	13.7
Age 13-17	100.0	83.1	76.5	9.9	5.5	1.9	14.4

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
a-Number is too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance, Region, and State, 1986

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
			(In thousands)				
Total.	206,023	152,898	136,123	23,828	24,883	16,985	37,027
New England	10,916	8,805	7,939	1,189	990	587	1,333
Maine	953	732	635	118	105	a	145
New Hampshire	883	745	689	99	a	a	101
Vermont	461	359	326	a	a	a	69
Massachusetts	5,085	4,095	3,688	528	513	404	605
Rhode Island	824	700	633	94	83	a	69
Connecticut	2,710	2,173	1,969	350	289	183	345
Middle Atlantic	31,893	24,405	22,071	3,338	3,675	2,982	4,567
New York	15,286	11,052	10,030	1,551	2,008	1,707	2,556
New Jersey	6,682	5,393	4,858	729	585	453	825
Pennsylvania	9,925	7,960	7,183	1,058	1,082	821	1,185
East North Central	36,378	27,956	25,259	3,880	4,488	3,447	5,133
Ohio	9,356	7,153	6,499	939	1,036	838	1,409
Indiana	4,654	3,630	3,258	541	342	182	833
Illinois	10,093	7,606	6,838	1,065	1,333	1,040	1,481
Michigan	8,133	6,199	5,638	860	1,306	1,037	965
Wisconsin	4,143	3,367	3,028	476	470	350	444
West North Central	15,209	11,944	10,000	2,463	1,544	1,166	2,122
Minnesota	3,670	2,931	2,418	636	475	397	389
Iowa	2,532	2,035	1,640	495	280	236	295
Missouri	4,391	3,328	2,941	471	471	340	714
North Dakota	548	443	325	143	a	a	87
South Dakota	595	463	349	138	a	a	103
Nebraska	1,383	1,069	897	239	130	86	234
Kansas	2,090	1,673	1,430	341	188	108	299
South Atlantic	34,639	25,581	22,717	4,050	3,892	2,116	6,393
Delaware	553	421	387	a	a	a	99
Maryland	3,972	3,133	2,869	396	350	211	617
District of Columbia	526	365	329	a	a	a	112
Virginia	4,799	3,308	3,466	473	626	260	622
West Virginia	1,621	1,106	959	189	297	218	295
North Carolina	5,364	3,997	3,574	644	533	295	985
South Carolina	2,840	2,092	1,888	330	406	232	468
Georgia	5,311	3,891	3,519	606	677	431	954
Florida	9.653	6 767	5.725	1,412	1,004	469	2,242
East South Central	12,973	8.658	7,665	1,526	1,800	1,182	2,950
Kentucky	3,139	2,151	1,895	340	448	304	659
Tennessee	4,010	2,725	2,429	470	620	380	826
Alabama	3,575	2.378	2,144	365	430	294	859
Mississippi	2,249	1,404	1,197	351	303	205	606
West South Central	23,290	15 494	13,827	2,582	2,656	1,542	5,861
Arkansas	2,007	1,312	1,153	246	295	165	487
Louisiana	3,920	2,548	2,234	520	599	416	904
Oklahoma	2,793	1,943	1,690	351	332	153	636
Texas	14,569	9,691	8,751	1,465	1,430	808	3,833
Mountain	11,354	8,351	7,191	1,482	1,085	305	2,242
Montana	715	525	408	153	88	a	134
Idaho	863	626	524	132	a	a	196
Wyoming	441	329	283	a	a	a	78
Colorado	2,769	2,052	1,778	374	384	200	450
New Mexico	1,249	827	670	190	142	a	325
Arizona	2,895	2,129	1,832	394	221	a	651
Utah	1,546	1,181	1,080	139	155	105	253
Nevada	878	682	617	99	95	a	154
Pacific	31,369	21,705	19,454	3,038	4,263	3,022	6,427
Washington	3,808	2,739	2,394	447	656	420	603
Oregon	2,401	1,753	1,573	218	233	167	478
California	23,874	16,217	14,629	2,219	3,270	2,434	5,142
Alaska	453	324	271	a	a	a	97
Hawaii	833	672	587	154	104	a	107

a–Number is too small to be statistically reliable.

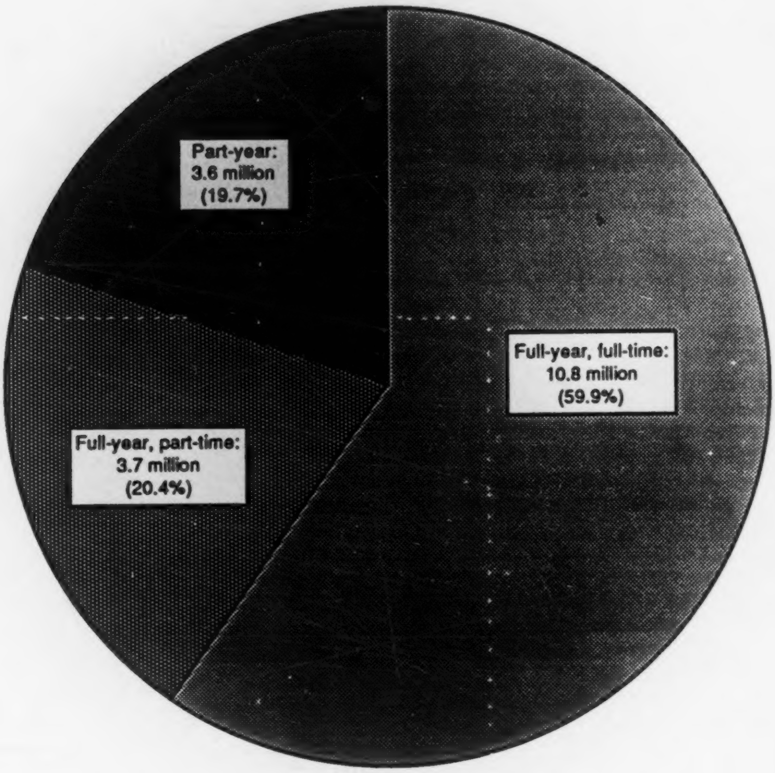
Nonelderly Population by Selected Sources of Health Insurance, Region, and State, 1986

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
			(percent within state)				
Total.	100.0%	73.5%	65.4%	11.5%	12.0%	8.2%	17.8%
New England	100.0	80.7	72.7	10.9	9.1	5.4	12.2
Maine	100.0	76.8	66.6	12.4	11.0	a	15.2
New Hampshire	100.0	84.4	78.0	11.3	a	a	11.5
Vermont	100.0	77.9	70.6	a	a	a	14.8
Massachusetts	100.0	80.5	72.5	10.4	10.1	7.9	11.9
Rhode Island	100.0	85.0	76.9	11.4	10.1	a	8.4
Connecticut	100.0	80.2	72.7	12.9	10.7	6.7	12.7
Middle Atlantic	100.0	76.5	69.2	10.5	11.5	9.3	14.3
New York	100.0	72.3	65.6	10.1	13.1	11.2	16.7
New Jersey	100.0	80.7	72.7	10.9	8.8	6.8	12.4
Pennsylvania	100.0	80.2	72.4	10.7	10.9	8.3	11.9
East North Central	100.0	76.8	69.4	10.7	12.3	9.5	14.1
Ohio	100.0	76.5	69.5	10.0	11.1	9.0	15.1
Indiana	100.0	78.0	70.0	11.6	7.4	3.9	17.9
Illinois	100.0	75.4	67.8	10.6	13.2	10.3	14.7
Michigan	100.0	76.2	69.3	10.6	16.1	12.7	11.9
Wisconsin	100.0	81.3	73.1	11.5	11.3	8.5	10.7
West North Central	100.0	78.5	65.8	16.2	10.2	7.7	13.9
Minnesota	100.0	79.9	65.9	17.3	12.9	10.8	10.6
Iowa	100.0	80.4	64.8	19.6	11.1	9.3	11.6
Missouri	100.0	75.8	67.0	10.7	10.7	7.8	16.3
North Dakota	100.0	80.8	59.2	26.0	a	a	15.9
South Dakota	100.0	77.9	58.6	23.2	a	a	17.4
Nebraska	100.0	77.3	64.8	17.3	9.4	6.2	16.9
Kansas	100.0	80.1	68.4	16.3	9.0	5.1	14.3
South Atlantic	100.0	73.8	65.6	11.7	11.2	6.1	18.5
Delaware	100.0	76.1	70.0	a	a	a	17.8
Maryland	100.0	78.9	72.2	10.0	8.8	5.3	15.5
District of Columbia	100.0	69.4	62.5	a	a	a	21.2
Virginia	100.0	79.4	72.2	9.8	13.0	5.4	13.0
West Virginia	100.0	68.2	59.2	11.7	18.3	13.5	18.2
North Carolina	100.0	74.5	66.6	12.0	9.9	5.5	18.4
South Carolina	100.0	73.7	66.5	11.6	14.3	8.2	16.5
Georgia	100.0	73.3	66.3	11.4	12.7	8.1	18.0
Florida	100.0	70.1	59.3	14.6	10.4	4.9	23.2
East South Central	100.0	66.7	59.1	11.8	13.9	9.1	22.7
Kentucky	100.0	68.5	60.4	10.8	14.3	9.7	21.0
Tennessee	100.0	68.0	60.6	11.7	15.5	9.5	20.6
Alabama	100.0	66.5	60.0	10.2	12.0	8.2	24.0
Mississippi	100.0	62.4	53.2	15.6	13.5	9.1	26.9
West South Central	100.0	66.5	59.4	11.1	11.4	6.6	25.2
Arkansas	100.0	65.3	57.4	12.3	14.7	8.2	24.3
Louisiana	100.0	65.0	57.0	13.3	15.3	10.6	23.1
Oklahoma	100.0	69.6	60.5	12.6	11.9	5.5	22.8
Texas	100.0	66.5	60.1	10.1	9.8	5.5	26.3
Mountain	100.0	73.6	63.3	13.0	9.6	2.7	19.7
Montana	100.0	73.5	57.0	21.5	12.4	a	18.8
Idaho	100.0	72.5	60.7	15.3	a	a	22.7
Wyoming	100.0	74.6	64.1	a	a	a	17.6
Colorado	100.0	74.1	64.2	13.5	13.9	7.2	16.3
New Mexico	100.0	66.3	53.6	15.2	11.4	a	26.1
Arizona	100.0	73.5	63.3	13.6	7.6	a	22.5
Utah	100.0	76.4	69.9	9.0	10.0	6.8	16.4
Nevada	100.0	77.7	70.3	11.3	10.8	a	17.6
Pacific	100.0	69.2	62.0	9.7	13.6	9.6	20.5
Washington	100.0	71.9	62.9	11.7	17.2	11.0	15.8
Oregon	100.0	73.0	65.5	9.1	9.7	7.0	19.9
California	100.0	67.9	61.3	9.3	13.7	10.2	21.5
Alaska	100.0	71.6	59.8	a	a	a	21.5
Hawaii	100.0	80.6	70.4	18.5	12.5	a	12.9

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

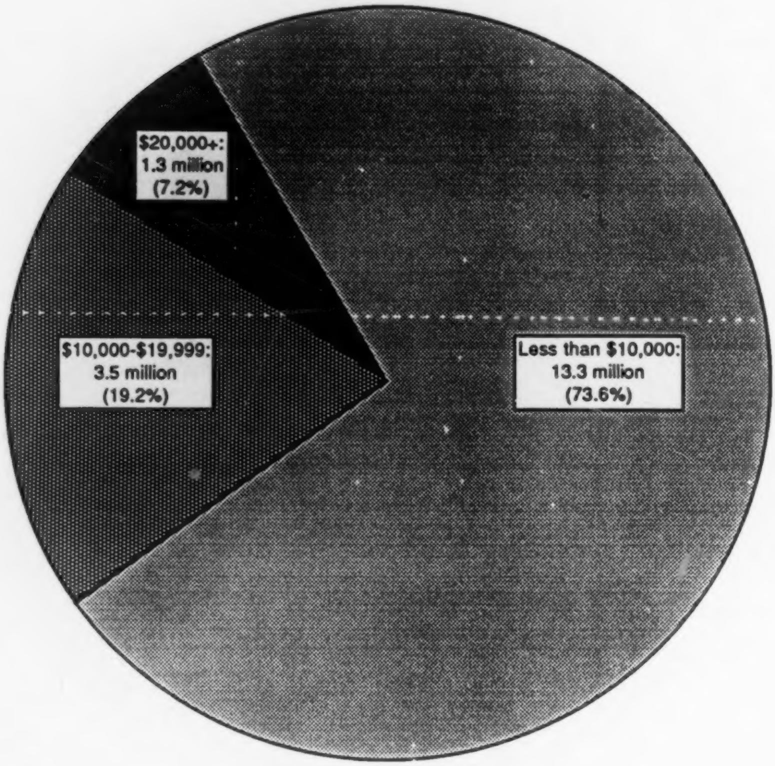
a—Number is too small to be statistically reliable.

Workers Age 18-64 Without Health Insurance by Own Work Status, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
Note: Each category may include workers who were unemployed at some time during the year.

Workers Age 18-64 Without Health Insurance by Personal Earnings, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Chairman **Stark**. Thank you.

Before we have Professor Brown's testimony, what percentage of children that have no insurance have parents who have insurance but it just doesn't cover dependents? Do you have any idea whether that is a small or large part?

Ms. **Chollet**. It is actually a surprisingly large part. In particular many of the workers who head these families are covered by employee plans, a surprisingly high large number, almost a third, something on the order of 27 percent. About one-third of those, about 10 percent of uninsured children, are living with an employer-insured worker who is not their parent or spouse. That is, we are dealing with nonstandard family units for about a third of those who might have access to employer plans.

That still leaves something in the order of 20 percent the uninsured children who live with an insured parent or spouse. These children may not have coverage if the parent or spouse is required to pay a premium to cover dependants.

From the data available to us it appears there are very, very few plans provided by employers that exclude altogether dependents' coverage. It is just that a contribution is increasingly common.

Chairman **Stark**. Professor Brown.

STATEMENT OF E. RICHARD BROWN, PH.D., ASSOCIATE PROFESSOR, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Mr. **Brown**. Thank you very much for the invitation to present my research findings about the problem of the uninsured and my views about some strategies that may help solve this problem.

Much of my work on health insurance coverage has been conducted in collaboration with my colleagues Drs. Robert Valdez and Hal Morgenstern at the UCLA School of Public Health. I would like to share with the Committee some of our research findings, which focus on conditions in California. We analyzed the health insurance coverage of the California population for the period 1979–1986, using data from the Current Population Surveys conducted by the U.S. Census Bureau. A recent report of our research is included with my written testimony, but I would like to highlight some of our findings.

Our data comes from the same source Dr. Chollet reported on. Our study found that the problem in California was more severe than in the country as a whole and conditions have been deteriorating more rapidly. In 1979, 17 percent of California's population under 65 years of age were uninsured (when the U.S. average was 15 percent), but by 1986, 21 percent of nonelderly Californians were without any coverage (when the U.S. rate was 18 percent). The California rate is thus about one-fifth higher than the U.S. average.

Between 1979 and 1986, the number of Californians without any health coverage increased from 3.5 million to more than 5.1 million. This increase of 1.6 million uninsured Californians is a nearly 50 percent increase in 7 years.

The problem in Los Angeles and some other parts of California is even more severe than for the state as a whole. In 1986, 26 percent of Los Angeles County's nonelderly population were without private or public health insurance coverage all year, up from 20 percent in 1979. More than 2 million Los Angeles residents are uninsured all year.

Among the 20 largest metropolitan areas in the United States, Los Angeles, Orange County, and San Diego have the first, second, and third largest proportions of uninsured nonelderly population, respectively.

The 1.6 million increase in the number of uninsured Californians was due partly to the growth in the state's population and partly to changes in the proportion of the population who have insurance coverage. In figure 1 on page A8, the steeper line reflects the number of people who were actually uninsured during this period and the line below it represents the growth in the number who would have been uninsured if the rate of insurance coverage had remained constant at the 1979 level of 17 percent. Thus, the number of uninsured people would have been about 4.3 million in 1986 if the rate had not changed, a growth of about 800,000 attributable to the increase in population.

The difference between these two lines represents the increase in the number of uninsured attributable to the growing rate at which people were uninsured—about 800,000, or one-half the total increase.

The proportion of uninsured children and adults increased in all age groups, but the percentage of young adults (18-29 years of age) without health insurance increased most dramatically—from 22 percent in 1979 to 30 percent in 1986, one and one-half times as large as the proportion of all nonelderly Californians.

The proportion of near-poor who are uninsured has increased dramatically. Near-poor children (those living in families with incomes between the federal poverty level and 150 percent of poverty) experienced a massive increase in the percentage who were uninsured—from 27 percent in 1979 to 40 percent in 1986, a rate that is nearly twice that of all nonelderly Californians.

During this same period, the number of uninsured poor and near-poor children increased dramatically from 493,000 in 1979 (44 percent of all uninsured children) to 877,000 in 1986 (56 percent of all uninsured children). Part of this increase in the number of uninsured low-income children is due to the steep increase in the rate at which near-poor children were uninsured (27 percent to 40 percent) and part of the increase is due to the dramatic increase in the percentage of children living in poverty—from 16 percent in 1979 to 23 percent in 1986.

The percentage of uninsured adults increased among all income groups. The proportion of uninsured poor adults increased substantially from their already very high rate, from 41 percent in 1979 to 46 percent in 1986. The increase for the near-poor was the most dramatic—from 29 percent in 1979 to 39 percent in 1986.

However, a large proportion of the uninsured are not poor at all: 27 percent of all uninsured Californians (1.4 million) had family incomes at least three times the poverty level in 1986. That is approximately $33,000 to $35,000 a year for a family of four.

The percentage of Latino children who were uninsured rose substantially from their already high level of 23 percent in 1979 to 33 percent in 1986, the highest level among all ethnic groups.

As with Latino children, the proportion of Latino adults who are uninsured jumped from 24 percent in 1979 to 37 percent in 1986, a proportion that is one and three-fourths as large as the rate for all nonelderly Californians. No other ethnic group showed such a steep and consistent increase over this 7 year period.

Non-Latino whites consistently have had the lowest rates of being uninsured among all ethnic groups, although their rates in California have averaged about two percentage points higher than for the United States as a whole.

The number of Californians (16–64 years of age) who work for a living but have no health insurance coverage rose from 1.7 million in 1979 to 2.7 million in 1986. This growth of 1 million uninsured workers represented an increase from 15 percent of all workers in 1979 to 20 percent of all workers in 1986.

Throughout this period, California's rates were about one-third higher than for the United States as a whole. For example, 12 percent of U.S. workers were uninsured in 1979, compared with 15 percent for California, and 15 percent of U.S. workers in 1986 were uninsured, compared with 20 percent for California.

Working people comprise more than half the uninsured. The number of uninsured workers has grown faster than the number of uninsured persons not in the labor force and faster than the number of uninsured children, so that uninsured workers now represent a somewhat larger share of the uninsured than they did in 1979.

As figure 2 on page A9 demonstrates, in 1986, uninsured workers represented 53 percent of the uninsured population, compared with 50 percent in 1979.

The uninsured rate rose among the self-employed and private-sector employees. The proportion of government employees who were uninsured hovered between 6 percent to 8 percent from 1979 to 1986, while the proportion of self-employed workers who were uninsured increased sharply, from 30 percent to 37 percent.

The percentage of employees of private-sector firms who were uninsured increased steadily from 15 percent in 1979 to 20 percent in 1986. They alone comprised 43 percent of all uninsured people in California.

The probability of being uninsured increased sharply among full-time and part-time employees (not including self-employed workers). Among full-time full-year employees (those who worked at least 35 hours a week for at least 50 weeks a year), the proportion who have no health insurance rose from 9 percent in 1979 to 12 percent in 1986. Among full-time part-year employees (those who worked less than 50 weeks), the uninsured rate rose from 21 percent to 28 percent. The percentage of part-time employees who are uninsured rose from 19 percent in 1979 to 24 percent in 1986.

Low-income full-time employees are far more likely to be uninsured than are more-affluent employees. Among all full-time (part-year and full-year) employees in California in 1986, 48 percent of those with family incomes below 150 percent of the poverty level were uninsured compared to 12 percent of those with family incomes above that level.

I think that speaks to the issue of the ability of these uninsured people to be able to contribute to the health insurance plans from their own resources.

Full-time full-year employees are now a larger share of all uninsured employees. As figure 3 on page A10 shows, in 1986, uninsured full-time full-year employees represented 42 percent of all uninsured employees, up from 34 percent in 1979.

Because most people still get their health insurance through their employment, it is not surprising that increases in the proportion of full-time employees who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers (please see figures 4, 5, and 6 on page A11). The percentage of full-time full-year employees who received health insurance as a fringe benefit fell from 78 percent in 1979 to 75 percent by 1986, while the percentage of full-time part-year employees with this benefit was about one-third lower than for full-year employees, decreasing from 51 percent in 1979 to 45 percent in 1986.

The proportion of employees who received health insurance as a fringe benefit is much lower in some industries than in others. Among full-time full-year employees, the proportion with this fringe benefit was lower in the personal services sector (41 percent), agriculture, forestry and fisheries (44 percent), the retail sector (61 percent), and construction (66 percent) than in, for example, transportation (81 percent), professions (81 percent), and durable goods manufacturing (86 percent).

We found the proportions of Latino employees and those in other ethnic groups who receive health insurance as a fringe benefit has declined. But these decreases are not accounted for by shifts in the labor force from full-year to part-year or full-time to part-time employment.

Why is the growing lack of health insurance a problem? Compared to people with health insurance coverage, the uninsured have much less access to necessary medical care (see table 1 in prepared statement). A 1977 study by the U.S. National Center for Health Services Research found that insured persons averaged 3.7 physician visits per year, 54 percent more than the average of 2.4 for people without insurance. Furthermore, this difference in use of health services does not seem to be due only to differences in health status between the insured and the uninsured since, among people who were in fair to poor health, the insured averaged 68 percent more physician visits per year than the uninsured. They also found that insured people received 91 percent more days of hospitalization.

Similarly, a 1986 study by the Robert Wood Johnson Foundation found that, compared to insured people, the uninsured were less likely to see a physician in a 12-month period, less likely to get their young children adequately immunized, less likely to receive prenatal care in the first trimester of pregnancy, less likely to have their blood pressure checked, and less likely to see a physician if they had serious symptoms.

Not only do the uninsured have less access to care; their access has deteriorated during the 1980's. The Robert Wood Johnson Foundation study found substantial deterioration in the access to care of all Americans between their survey in 1986 and an earlier one in 1982. In that 4-year period, the percent of the uninsured with a regular source of care and those who saw a physician within 1 year declined 13 percent, and the average number of physician visits per uninsured persons fell 16 percent. (See table 2.)

The little research that has been conducted on the impact on people's health of being uninsured suggests that reduced access to medical care due to lack of insurance coverage may contribute to the worsening of health status, especially among persons with chronic illness.

Everyone pays for care to the uninsured. Lack of health insurance also creates financial burdens on health care providers and government. The growing numbers of uninsured people are reflected in the mounting financial pressures public hospitals, many nonprofit hospitals, and community clinics experience from uncompensated care they provide.

Uncompensated care (bad debts and charity care) cost California's hospitals $827 million in fiscal year 1984-85, up from $531 million in 1981-82. In inflation-adjusted dollars, uncompensated care increased 27 percent in just 3 years. Taxpayers shoulder the financial burden of uncompensated care provided by California's county hospitals—$345 million in 1984-85. This problem is likely to worsen as the number of AIDS patients, including those who are medically indigent, increases during the new few years.

Private hospitals in California provided the other $481 million of uncompensated care in 1984-85. Private hospitals shifted the costs of much of their uncompensated care to privately insured patients and their employers, who pay most of their health insurance premiums. But as cost-shifting has become more difficult over the last few years, more and more private hospitals have closed their trauma centers and shut their emergency room doors to "911" rescue ambulances in an effort to decrease their financial burdens resulting from uninsured patients. At this very moment in Los Angeles, 11 hospitals in the downtown Los Angeles area are now threatening to downgrade their emergency rooms in this way, an action that would create a black hole for emergency care that could affect hundreds of thousands of people.

The number and the proportion of nonelderly Californians who are uninsured have increased dramatically. Rapidly rising proportions of children, young adults, lower-income and minority Californians, full-time and part-time workers, and even many more affluent families and individuals have no protection against health care expenses all year long. Similar trends have been identified nationally, although the problem is more severe in California than in much of the rest of the nation.

The results of this mounting problem are felt by all Californians, as they are by all Americans. The uninsured experience it directly in the form of less access to needed medical care. All of us bear the burden of paying for the minimal care that is provided to this population. And essential emergency and trauma services are increasingly being denied to all people in many communities because of the burden posed by treatment provided to the uninsured. The problem of the uninsured already has reached crisis proportions. It urgently requires public policy action.

But what solution strategies would be appropriate? Congress and the states have opted for partial solutions, extending health insurance or public program entitlement to some, but not all, of those in need. In the past few years, these measures have added small increments to Medicaid eligibility, created risk pools for some of the people who have been denied health insurance because of existing medical conditions, allowed some people who have lost employer-provided health insurance to buy it through their employers at group rates, and created multiple employer trusts for small employers who want to offer health insurance to their employees but find it too expensive to do so. By themselves, these programs seem worthwhile. But this incremental strategy has added new patches to a badly frayed crazy quilt. Specifically targeted solutions, whether at the national or state level (even those that are as broad in scope as the recently enacted Massachusetts legislation), will add more fragments to an already fragmented, increasingly confusing, ever more costly system of health care. A great deal of political energy seems directed at enacting bits and pieces of solutions, giving the impression of "solving the problem of the uninsured" but not meeting the needs of the great majority of uninsured and underinsured Americans.

Somewhat more sweeping are proposals like your own to mandate employers to provide health insurance to their employees and dependents. This strategy would benefit about two-thirds of the uninsured, certainly a welcome relief to them and to public and private providers who now care for them. However, as you know, these bills would exclude about 14 million uninsured people, and the burden this simple solution would impose on small, especially low-wage paying employers would be very great. Moreover, an employer mandate would not solve numerous other systemic problems, such as continually rising health care costs, the fragmentation of health programs and plans, the regressive methods we now use to finance health insurance, and the misallocation of resources away from preventive and primary care for everyone to excessive use of expensive technologies that benefit only a few. Perhaps worst of all, enactment of an employer mandate would lull many people into thinking that these problems have been solved.

I and many other analysts believe the time has come for a more thorough overhaul of our health care system, particularly the way we finance and pay for care. A national health insurance system is needed to assure entitlement to everyone, to promote equitable access to quality care, to allocate our resources more effectively and efficiently, and to control the amount of money that we as a society spend on health care.

A universal, comprehensive national health program is essential to achieve these goals. Such a system should be progressively financed, that is, with people's contributions related to their ability to pay, not to how much they need health services, which is the way most private health insurance premiums are now set. It should pay for health services in a manner that encourages appropriate levels of care, and that assures that everyone will receive needed services to prevent illness, diagnose and treat illnesses that occur, and promote rehabilitation that will help people lead fulfilling lives and function socially and economically.

National health insurance has wide public support. Recent public opinion polls have found strong support at the national level among about two-thirds of adult respondents, although support has been even stronger in California where the proportion of the population without insurance coverage is greater than the national average. In a poll in Orange County, California, an area that is not known for its liberal political views, 75 percent of respondents favored national health insurance, including 67 percent of the Republicans.

I think that very soon, as health insurance premiums continue their upward spiral and as labor-management conflicts over health benefits increase, large employers and business coalitions will decide it is time to end their historic role of arranging and paying for health insurance for their employees. If powerful business organizations begin to lend their support to national health insurance as an alternative, what seems politically impossible today will become the consensus direction. It is my hope that Congress will provide the early leadership we need to enact national health insurance, matching the strong support for this necessary solution to the problems of the uninsured and the underinsured. Thank you, Mr. Chairman and Members of the committee, for considering my views.

[The prepared statement and attachments follow:]

STATEMENT OF E. RICHARD BROWN, PH.D., SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Thank you, Mr. Chairman, for the invitation to present my research findings about the problem of the uninsured and my views about some strategies that may help solve this problem.

Introduction

I am associate professor of public health at the UCLA School of Public Health. I have studied and written extensively about a broad range of health policies, programs and institutions, with particular emphasis on issues that affect the access of low-income people to health care. Recently I have concentrated on problems and policy issues related to persons without health insurance.

Much of my work on health insurance coverage has been conducted in collaboration with my colleagues Drs. Robert Valdez and Hal Morgenstern at the UCLA School of Public Health. I would like to share with the Committee some of our research findings, which focus on conditions in California. We analyzed the health insurance coverage of the California population for the period 1979-1986, using data from the Current Population Surveys conducted by the U.S. Census Bureau. A recent report of our research is included with my written testimony, but I would like to highlight some of our findings.[1]

The number of uninsured Californians increased dramatically between 1979 and 1986

Compared to a decade, more of the United States population is uninsured -- no private insurance, no Medicare and no Medicaid coverage throughout the year.

Our study found that the problem in California is more severe than in the country as a whole and conditions have been deteriorating more rapidly. In 1979, 17% of California's population under 65 years of age were uninsured (when the U.S. average was 15%), but by 1986, 21% of nonelderly Californians were without any coverage (when the U.S. rate was 18%). The California rate is thus about one-fifth higher than the U.S. average.

Between 1979 and 1986, the number of Californians without any health insurance coverage increased from 3.5 million to more than 5.1 million. This increase of 1.6 million uninsured Californians is a nearly 50% increase in seven years.

The problem in Los Angeles and some other parts of California is even more severe than for the state as a whole. In 1986, 26% of Los Angeles County's nonelderly population were without private or public health insurance coverage all year, up from 20% in 1979. More than 2 million Los Angeles residents are uninsured all year.

Among the 20 largest metropolitan areas in the United States, Los Angeles, Orange County, and San Diego have the first, second, and third largest proportions of uninsured nonelderly population, respectively.

Half the increase in the number of uninsured was due to rising rate of uninsured

The 1.6 million increase in the number of uninsured Californians was due partly to the growth in the state's population and partly to changes in the proportion of the population who have insurance coverage. In Figure 1 on page A8, the steeper line reflects the number of people who were actually uninsured during this period, and the line below it represents the growth in the number who would have been uninsured if the rate of insurance coverage had remained constant at the 1979 level of 17%. Thus, the number of uninsured people would have been about 4.3 million in 1986 if the rate had not changed, a growth of about 800,000 attributable to the increase in population.

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[1] Much of this testimony concerning research findings on the uninsured is adapted from E.R. Brown, R.B. Valdez, H. Morgenstern, P. Nourjah, and C. Hafner, *Changes in Health Insurance Coverage of Californians, 1979-1986*, Berkeley: California Policy Seminar, University of California, August 1988. This study, undertaken for the California Legislature, was funded by the California Policy Seminar.

The difference between these two lines represents the increase in the number of uninsured attributable to the growing *rate* at which people were uninsured -- about 800,000, or one-half the total increase.

Children and young adults are at greatest risk of being uninsured

The proportion of uninsured children and adults increased in all age groups, but the percentage of young adults (18-29 years of age) without health insurance increased most dramatically -- from 22% in 1979 to 30% in 1986, one and one-half times as large as the proportion of all nonelderly Californians.

The proportion of near-poor who are uninsured has increased dramatically

Near-poor children (those living in families with incomes between the federal poverty level and 150% of poverty) experienced a massive increase in the percentage who were uninsured -- from 27% in 1979 to 40% in 1986, a rate that is nearly twice that of all nonelderly Californians.

During this same period, the *number of uninsured poor and near-poor children* increased dramatically from 493,000 in 1979 (44% of all uninsured children) to 877,000 in 1986 (56% of all uninsured children). Part of this increase in the number of uninsured low-income children is due to the steep increase in the *rate* at which near-poor children were uninsured (27% to 40%), and part of the increase is due to the dramatic increase in the percentage of children living in poverty (from 16% in 1979 to 23% in 1986).

The percentage of uninsured adults increased among all income groups. The proportion of uninsured poor adults increased substantially from their already very high rate, from 41% in 1979 to 46% in 1986. The increase for the near-poor was the most dramatic -- from 29% in 1979 to 39% in 1986.

The proportion of uninsured adults with family incomes between 150% and 299% of poverty also rose substantially, from 22% in 1979 to 27% in 1986. The percentage of uninsured adults with family incomes at least 300% of poverty increased very slightly over this period, from 9% to 11%.

However, a large proportion of the uninsured are not poor at all: 27% of all uninsured Californians (1.4 million) had family incomes at least three times the poverty level in 1986.

Latino children and adults experienced startling increases

The percentage of Latino children who were uninsured rose substantially from their already high level of 23% in 1979 to 33% in 1986, the highest level among all ethnic groups.

The proportion of uninsured black children increased at the end of this period, from 19% in 1979 to 20% in 1985 and then to 29% in 1986, which may indicate a dramatic change in the trend, a one-year anomaly, or sampling error. The uninsured rates of other ethnic groups fluctuated from year-to-year.

As with Latino children, the proportion of Latino adults who are uninsured jumped from 24% in 1979 to 37% in 1986, a proportion that is one and three-fourths as large as the rate for all nonelderly Californians. No other ethnic group showed such a steep and consistent increase over this seven-year period.

Non-Latino whites consistently have had the lowest rates of being uninsured among all ethnic groups, although their rates in California have averaged about two percentage points higher than for the U.S. as a whole.

The proportion of workers who are uninsured increased

The number of Californians (16-64 years of age) who work for a living but have no health insurance coverage rose from 1.7 million in 1979 to 2.7 million in 1986. This growth of 1 million uninsured workers represented an increase from 15% of all workers in 1979 to 20% of all workers in 1986.

Throughout this period, California's rates were higher than for the U.S. as a whole. For example, 12% of U.S. workers were uninsured in 1979, compared with 15% for California, and 15% of U.S. workers in 1986 were uninsured, compared with 20% for California.

Working people have become a larger proportion of the uninsured

Working people comprise more than half the uninsured. The number of uninsured workers has grown faster than the number of uninsured persons not in the labor force and faster than the number of uninsured children, so that uninsured workers now represent a somewhat larger share of the uninsured than they did in 1979.

As Figure 2 on page A9 demonstrates, in 1986, uninsured workers represented 53% of the uninsured population, compared with 50% in 1979; nonworking adults represented 20% of the uninsured, compared with 22% in 1979; and children under 16 years of age represented 27%, down slightly from their 28% share in 1979.

The uninsured rate rose among the self-employed and private-sector employees

The proportion of government employees who were uninsured hovered between 6%-8% from 1979 to 1986, while the proportion of self-employed workers who were uninsured increased sharply, from 30% to 37%.

The percentage of employees of private-sector firms who were uninsured increased steadily from 15% in 1979 to 20% in 1986. They alone comprised 43% of all uninsured people in California.

The proportion of uninsured full- and part-time employees increased

The probability of being uninsured increased sharply among full-time and part-time employees (not including self-employed workers). Among full-time full-year employees (those who worked at least 35 hours a week for at least 50 weeks a year), the proportion who have no health insurance rose from 9% in 1979 to 12% in 1986. Among full-time part-year employees (those who worked less than 50 weeks), the uninsured rate rose from 21% to 28%. The percentage of part-time employees who are uninsured rose from 19% in 1979 to 24% in 1986.

Low-income full-time employees are far more likely to be uninsured than are more-affluent employees. Among all full-time (part-year and full-year) employees in California in 1986, 48% of those with family incomes below 150% of the poverty level were uninsured compared to 12% of those with family incomes above that level.

Full-time full-year employees are now a larger share of all uninsured employees. As Figure 3 on page A10 shows, in 1986, uninsured full-time full-year employees represented 42% of all uninsured employees, up from 34% in 1979.

The proportion of employees with health insurance as a fringe benefit has fallen

Because most people still get their health insurance through their employment, it is not surprising that increases in the proportion of full-time employees who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers (please see Figures 4, 5 and 6 on page A11). The percentage of full-time full-year employees who received health insurance as a fringe benefit fell from 78% in 1979 to 75% by 1986, while the percentage of full-time part-year employees with this benefit was about one-third lower than for full-year employees, decreasing from 51% in 1979 to 45% by 1986.[2]

The proportion of employees who received health insurance as a fringe benefit is much lower in some industries than in others. Among full-time full-year employees, the proportion with this fringe benefit was lower in the personal services sector (41%), agriculture, forestry and fisheries (44%), the retail sector (61%), and construction (66%) than in, for example, transportation (81%), professions (81%), and durable goods manufacturing (86%).

We found that the proportions of Latino employees and those in other ethnic groups who receive health insurance as a fringe benefit has declined. But these decreases are not accounted for by shifts in the labor force from full-year to part-year or full-time to part-time employment.[3]

Why is the growing lack of health insurance a problem?

Compared to people with health insurance coverage, the uninsured have much less access to necessary medical care (please see Table 1 below). A 1977 study by the U.S. National Center for Health Services Research found that insured persons averaged 3.7 physician visits per year, 54% more than the average of 2.4 per year for people without insurance. Furthermore, this difference in use of health services does not seem to be due only to differences in health status between the insured and the uninsured since, among people who were in fair or poor health, the insured averaged 68% more physician visits per year than the uninsured. They also found that insured people received 91% more days of hospitalization.

Similarly, a 1986 study by the Robert Wood Johnson Foundation found that, compared to insured people, the uninsured were less likely to see a physician in a 12-month period, less likely to get their young children adequately immunized, less likely to receive prenatal care in the first trimester of pregnancy, less likely to have their blood pressure checked, and less likely to see a physician if they had serious symptoms.

---

[2] For an explanation as to *why* the percentage of employees with health insurance as a fringe benefit rose as California and the nation entered the deep recession of the early 1980s, please see Brown et al., *Changes in Health Insurance Coverage of Californians, 1979-1986*, p. 18.

[3] Among Latino employees a greater proportion worked full-time for the full year in 1986 (59%) than in 1979 (50%), and a smaller proportion worked full-time for part of the year (25% in 1986 compared to 34% in 1979). Part-time employees did not change as a proportion of all Latino employees (16% in both 1979 and 1986). Similar trends were found among other ethnic groups as well.

Table 1. Access to Health Care of Insured and Uninsured Persons, U.S.

	Insured	Uninsured
Average physician visits per year (1977)	3.7	2.4
Average physician visits per year among people in fair or poor health (1977)	6.9	4.1
Percent with physician visit in a year (1986)	68%	59%
Percent young children with adequate immunizations (1986)	94%	81%
Percent pregnant women with prenatal care in first trimester (1986)	85%	80%
Percent of persons with blood pressure check in a year (1986)	60%	50%
Percent with serious symptoms who saw physician in 30 days (1986)	61%	32%

Source: (1977 data) K. Davis, D. Rowland, "Uninsured and Underserved: Inequities in Health Care in the United States," *Milbank Memorial Fund Quarterly*, 1983, *61*:149-176; (1986 data) H.E. Freeman, "Americans Report on Their Access to Health Care: The 1986 Robert Wood Johnson Foundation Survey," Institute for Social Science Research, University of California, Los Angeles, May 1987.

Not only do the uninsured have less access to care; their access has deteriorated during the 1980s. The Robert Wood Johnson Foundation study found substantial deterioration in the access to care of all Americans between their survey in 1986 and an earlier one in 1982. In that four-year period, the percent of the uninsured with a regular source of care and those who saw a physician within a year declined 13%, and the average number of physician visits per uninsured person fell 16% (please see Table 2 below).

Table 2. Changes in Access to Health Care of Uninsured, 1982-1986, U.S.

Uninsured Population	1982	1986	Percent Change
Percent with regular source of care	79%	69%	-13%
Percent who saw physician in past year	68%	59%	-13%
Average number of physician visits in year	3.8	3.2	-16%

Source: H.E. Freeman, "Americans Report on Their Access to Health Care: The 1986 Robert Wood Johnson Foundation Survey," Institute for Social Science Research, University of California, Los Angeles, May 1987; and H.E. Freeman et al., "Americans Report on Their Access to Health Care," *Health Affairs*, 1987, *6*:6-18.

The little research that has been conducted on the impact on people's health of being uninsured suggests that *reduced access to medical care due to lack of insurance coverage may contribute to the worsening of health status*, especially among persons with chronic illnesses.[4]

---

[4] For example, a study at the UCLA Medical Center found that loss of Medi-Cal coverage had a serious adverse impact on the health status of patients with diabetes and high blood pressure. N. Lurie, N.B.

Everyone pays for care to the uninsured. Lack of health insurance also creates financial burdens on health care providers and government. The growing numbers of uninsured people are reflected in the mounting financial pressures public hospitals, many nonprofit hospitals, and community clinics experience from uncompensated care they provide.

Uncompensated care (bad debts and charity care) cost California's hospitals $827 million in fiscal year 1984-85, up from $531 million in 1981-82. In inflation-adjusted dollars, uncompensated care increased 27% in just three years.[5] Taxpayers shoulder the financial burden of uncompensated care provided by California's county hospitals -- $345 million in 1984-85. This problem is likely to worsen as the number of AIDS patients, including those who are medically indigent, increases during the next few years.

Private hospitals in California provided the other $481 million of uncompensated care in 1984-85. Private hospitals shifted the costs of much of their uncompensated care to privately insured patients and their employers, who pay most of their health insurance premiums. But as cost-shifting has become more difficult over the last few years, more and more private hospitals have closed their trauma centers and shut their emergency room doors to "911" rescue ambulances in an effort to decrease their financial burdens resulting from uninsured patients. Eleven hospitals in the downtown Los Angeles area are now threatening to downgrade their emergency rooms in this way, an action that would create a black hole for emergency care that could affect hundreds of thousands of people.

Need for public policy action

The number and the proportion of nonelderly Californians who are uninsured have increased dramatically. Rapidly rising proportions of children, young adults, lower-income and minority Californians, full-time and part-time workers, and even many more affluent families and individuals have no protection against health care expenses all year long. Similar trends have been identified nationally, although the problem is more severe in California than in much of the rest of the nation.

The results of this mounting problem are felt by all Californians, as they are by all Americans. The uninsured experience it directly in the form of less access to needed medical care. All of us bear the burden of paying for the minimal care that is provided to this population. And essential emergency and trauma services are increasingly being denied to all people in many communities because of the burden posed by treatment provided to the uninsured. The problem of the uninsured already has reached crisis proportions. It urgently requires public policy action.

But what solution strategies would be appropriate?

Congress and the states have opted for partial solutions, extending health insurance or public program entitlement to *some*, but not all, of those in need. In the past few years, these measures have added small increments to Medicaid eligibility, created risk pools for some of people who have been denied health insurance because of existing medical conditions, allowed some people who have lost employer-provided health insurance to buy it through their employers at group rates, and created multiple employer trusts for small employers who

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Ward, M.F. Shapiro, and R.H. Brook, "Termination from Medi-Cal: Does It Affect Health?" *New England Journal of Medicine*, 1984, *311*:480-484; and N. Lurie, N.B. Ward, M.F. Shapiro, C. Gallego, R. Vaghaiwalla, and R.H. Brook, "Termination of Medi-Cal Benefits: A Follow-up Study One Year Later," *New England Journal of Medicine*, 1986, *314*:1266-1268.

[5] T.G. Rundall, S. Sofaer, and W. Lambert, "Uncompensated Hospital Care in California: Private and Public Hospital Responses to Competitive Market Forces," presented at American Public Health Association annual meeting, New Orleans, October 21, 1987. The authors analyzed data from the Office of Statewide Health Planning and Development.

want to offer health insurance to their employers but find it too expensive to do so. By themselves, these programs seem worthwhile. But this incremental strategy has added new patches to a badly frayed crazy quilt. Specifically targetted solutions, whether at the national or state level (even those that are as broad in scope as the recently enacted Massachusetts legislation), will add more fragments to an already fragmented, increasingly confusing, ever more costly system of health care. A great deal of political energy seems directed at enacting bits and pieces of solutions, giving the impression of "solving the problem of the uninsured" but not meeting the needs of the great majority of uninsured and underinsured Americans.

Somewhat more sweeping are proposals to mandate employers to provide health insurance to their employees and dependents. This strategy would benefit about two-thirds of the uninsured, certainly a welcome relief to them and to public and private providers who now care for them. However, as you know, these bills would exclude about 14 million uninsured people, and the burden this simple solution would impose on small, especially low-wage paying employers would be very great. Moreover, an employer mandate would not solve numerous other systemic problems, such as continually rising health care costs, the fragmentation of health programs and plans, the regressive methods we now use to finance health insurance, and the misallocation of resources away from preventive and primary care for everyone to excessive use of expensive technologies that benefit only a few. Perhaps worst of all, enactment of an employer mandate would lull many people into thinking that these problems have been solved.

I and many other analysts believe the time has come for a more thorough overhaul of our health care system, particularly the way we finance and pay for care. A national health insurance system is needed to assure entitlement to everyone, to promote equitable access to quality care, to allocate our resources more effectively and efficiently, and to control the amount of money that we as a society spend on health care.

A *universal, comprehensive* national health program is essential to achieve these goals. Such a system should be progressively financed, that is, with people's contributions related to their ability to pay, not to how much they need health services, which is the way most private health insurance premiums are now set. It should pay for health services in a manner that encourages appropriate levels of care, and that assures that everyone will receive needed services to prevent illness, diagnose and treat illnesses that occur, and promote rehabilitation that will help people lead fulfilling lives and function socially and economically.

National health insurance has wide public support. Recent public opinion polls have found support at the national level among about two-thirds of adult respondents, although support has been even stronger in California where the proportion of the population without insurance coverage is greater than the national average.[6] In a poll in Orange County, California, an area that is not known for its liberal political views, 75 percent of respondents favored national health insurance, including 67% of Republicans.[7]

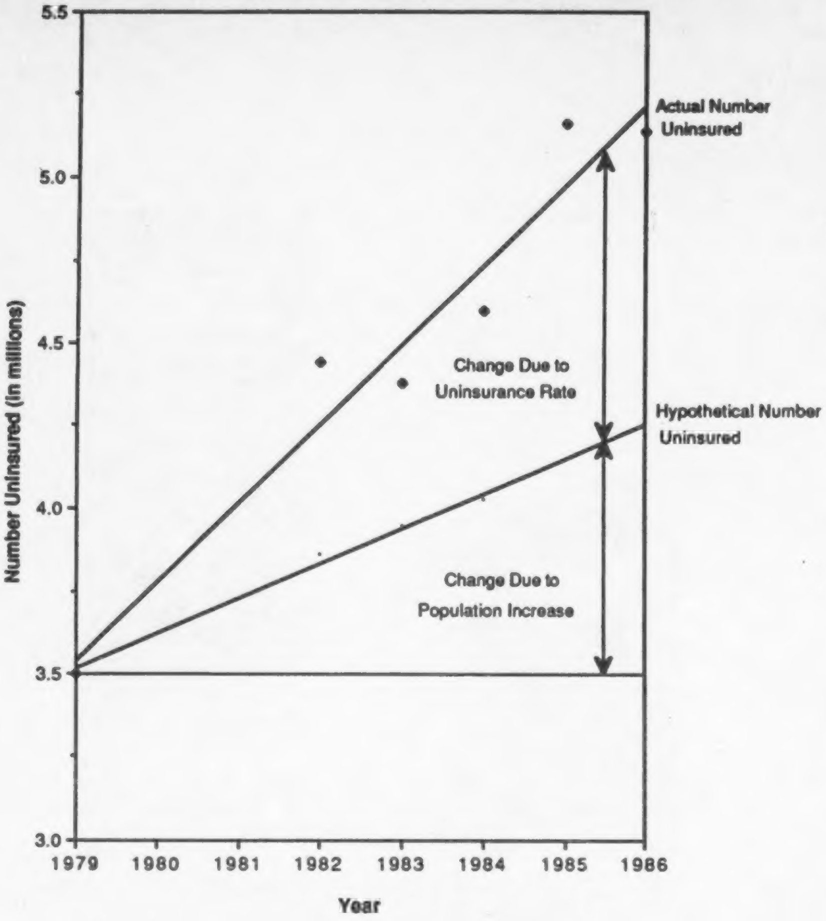
I think that very soon, as health insurance premiums continue their upward spiral and as labor-management conflicts over health benefits increase, large employers and business coalitions will decide it is time to end their historic role of arranging and paying for health insurance for their employers. If powerful business organizations begin to lend their support to national health insurance as an alternative, what seems politically impossible today will become the consensus direction. It is my hope that Congress will provide the early leadership we need to enact national health insurance, matching the strong popular support for this necessary solution to the problems of the uninsured and the underinsured. Thank you, Mr. Chairman and members of the Committee, for considering my views.

---

[6] A. Parachini, "Health Care Debate: Who Will Pay the Way?" *Los Angeles Times*, Aug. 30, 1987, pt. VI, pp. 1, 10-12; A. Parachini, "AIDS Is No. 1 Health Issue in State Poll," *Los Angeles Times*, March 29, 1988, pt. V, pp. 1, 2, 7; and G. Pokorny, "Report Card on Health Care," *Health Management Quarterly*, 1988, *10*:3-7.

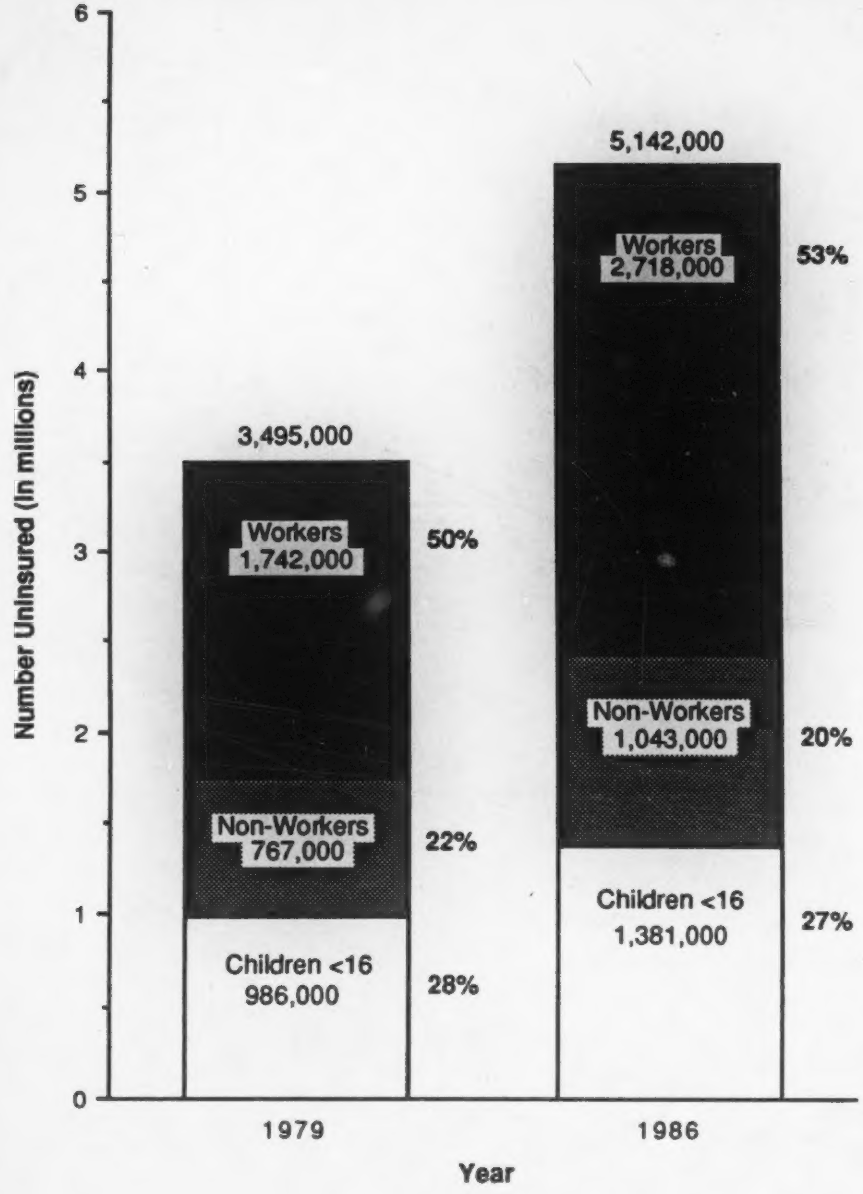
[7] S. Peterson, "Poll: 75% in OC Favor National Health Insurance," *Orange County Register*, Sept. 22, 1987, pp. A1, A10-11.

Figure 1. Components of Change in Number of Uninsured Nonelderly Persons: Actual Number Versus Hypothetical Number of Uninsured If Uninsurance Rate Remained Constant at 17%, California 1979-1986



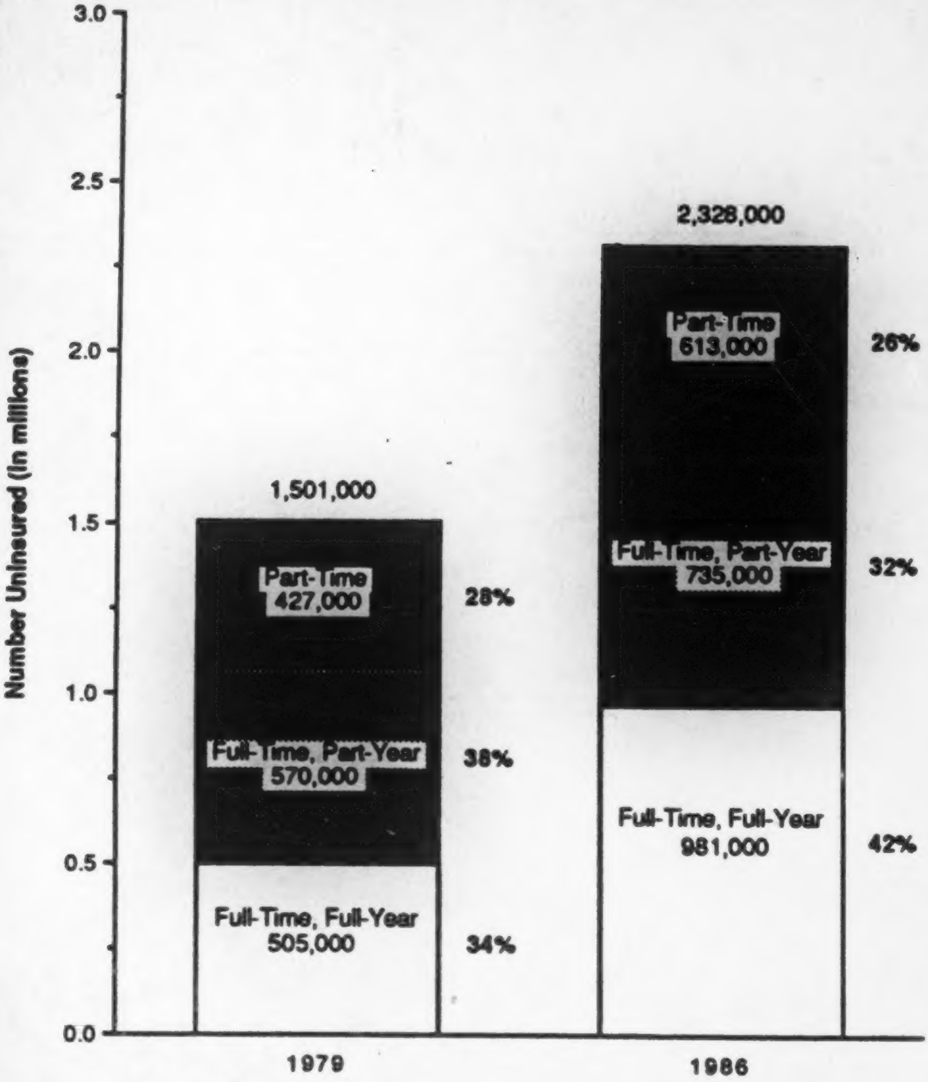
Source: March Current Population Survey data tapes 1980, 1983-1987

Figure 2. Number and Percent of Nonelderly Uninsured Persons By Labor Force Participation in 1979 and 1986, California



Source: March Current Population Survey data tapes, 1980, 1987

Figure 3. Number and Percent of Uninsured Employees by Full- & Part-Time Employment in 1979 & 1986, California



Source: March Current Population Survey data tapes, 1980, 1987

Figure 4. Percentage of Full-Time, Full-Year Employees With Health Insurance As Fringe Benefit, California, 1979-1986

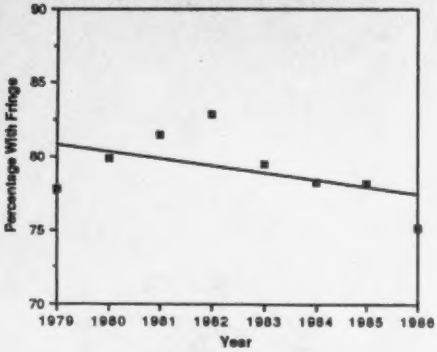


Figure 5. Percentage of Full-Time, Part-Year Employees With Health Insurance As Fringe Benefit, California, 1979-1986

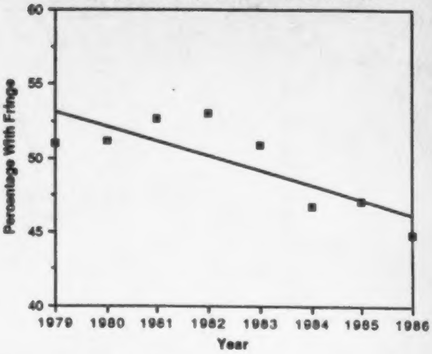
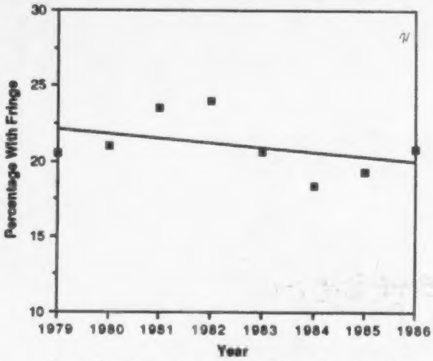


Figure 6. Percentage of Part-Time Employees With Health Insurance as Fringe Benefit, California, 1979-1986



Source: March Current Population Survey data tapes, 1980-1987

CHANGES IN HEALTH INSURANCE COVERAGE OF CALIFORNIANS, 1979-1986

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Executive Summary

The number of Californians who are uninsured increased from 3.5 million in 1979 to 5.1 million in 1986, a growth of more than 50%. These are people who had no private health insurance, no Medicare coverage, and no Medi-Cal eligibility during the entire year.

We estimate that about half this increase of 1.6 million was due to growth in California's population, and half – 800,000 uninsured children and adults – were added by the rising rate at which people were uninsured. In 1979, 17% of nonelderly Californians were uninsured all year, but by 1985 the rate reached 22%.

Lack of insurance coverage has increased among all age groups. Young adults experienced the steepest rise, from 22% in 1979 to 30% in 1986, but children 6-17 years of age and adults 45-54 years of age also experienced fairly sharp increases.

Near-poor children and adults (those with family incomes between 100% and 150% of the federal poverty level) suffered severe deterioration in their health insurance coverage. The proportion of near-poor children who were uninsured grew from 27% in 1979 to 40% in 1986, and the proportion of near-poor adults without insurance rose from 29% to 39% during the same period. Poor adults (with family incomes below poverty), lower-moderate income adults (with family incomes between 150% and 299% of the poverty level), and more-affluent children and adults (with family incomes of at least 300% of the poverty level) all experienced decreased rates of insurance coverage. The number of uninsured poor and near-poor children increased from 493,000 in 1979 to 877,000 in 1986, and uninsured poor and near-poor adults, from 812,000 to 1,427,000.

However, lack of health insurance is not just a problem of the poor. **One-fourth of the uninsured – 1.4 million children and adults – have family incomes at least three times the poverty level.**

Latino children and adults sustained dramatic declines in health insurance coverage. The percentage of Latino children without health insurance increased from 23% in 1979 to 33% in 1986, while the rate for adults rose from 24% in 1979 to 37% in 1986. Rates for other ethnic groups fluctuated without showing clearly increasing or decreasing trends, although data for black children and adults showed a substantial jump in the proportion of uninsured in 1986.

Among adults (16-64 years of age) who did not work throughout the year – including homemakers, students, and those who were retired, ill, or unemployed all year – a large percentage were uninsured, but their rate was only somewhat higher in 1986 than in 1979 (27% v. 24%).

The proportion of workers who are uninsured increased from 15% in 1979 to 20% in 1986, a rate that was one-third higher than for the U.S. as a whole. The proportion of self-employed workers who were uninsured increased sharply between 1979 and 1986, ending this period at 37%. The percentage of employees of private-sector firms who were uninsured increased steadily from 15% in 1979 to 20% in 1986, an increase of nearly 868,000 during this eight-year period.

More than half the uninsured are working people. More than one-fourth are their children. **Working people and their families together comprise 80% of all uninsured Californians.**

The probability of being uninsured increased sharply among full-time and part-time employees between 1979 and 1986. In 1986, 981,000 employees worked full-time for the full-year but remained uninsured. They represented 42% of all uninsured employees in 1986, up from 34% in 1979. In 1986, 48% of all low-income full-time employees (with family incomes below 150% of poverty) were uninsured, four times the rate for more affluent full-time employees.

For full-time employees, the increases in the proportion who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers, from 78% of full-time full-year employees in 1979 to 75% in 1986. During this same period, the percentage of full-time part-year employees with this fringe benefit was about one-third lower than for those who worked a full year, and it declined from 51% in 1979 to 45% in 1986.

The proportion of employees with health insurance as a fringe benefit is lower among service, retail, construction and agricultural employees. Latino employees experienced the biggest drop in this fringe benefit, from 53% in 1979 to 46% 1986.

The growing lack of health insurance is a problem because:

> **The uninsured have less access to care,** and access for the uninsured has deteriorated.
>
> **Lack of health insurance also creates financial burdens on health care providers and government.** Uncompensated care (charity and bad debts) cost California hospitals $827 million in fiscal year 1984-85, including $481 million from private hospitals and $345 million from county hospitals.
>
> Although state and county programs spent a total of $1,112 million on the medically indigent population in 1986, **public spending has not kept up with the growth of the uninsured low-income population and with inflation.** Between 1983 and 1986, the number of very-low-income uninsured people (the medically indigent) in California grew from 2,077,000 to 2,304,000, a 10.9% increase. But after adjusting for inflation, **total state and county spending for indigent medical care increased less than 1%. As a consequence, inflation-adjusted public spending per medically indigent person in California fell 9% in just three years.**

Changes in Health Insurance Coverage of Californians, 1979-1986

Introduction

Health insurance coverage of the United States population has been declining in the last decade. In 1977, 13% of the nonelderly population were uninsured, and by 1985, 18% were without health insurance. An earlier study demonstrated that the problem in California is more severe than for the rest of the country. In 1985, 22% of California's population under 65 years of age were uninsured.[1]

The research methods used in this report

Considering the greater problem in California and the increase nationally, we analyzed the health insurance coverage of the California population for the period 1979-1986. To study the population covered by private and public health care plans and those not covered by any program, we analyzed data from the Current Population Surveys (CPS). The CPS is valuable because it provides annual population-based data on insurance coverage as well as extensive information about employment, income, and demographic factors.

However, the CPS also has some limitations. It counts people with coverage for even a brief period during the year as insured, and thus does not count as uninsured those who are without health insurance for less than a full year. The CPS therefore provides a conservative estimate of the magnitude of the uninsured population. In addition, the CPS does not assess whether an insured person's coverage is adequate. Thus, the CPS data permit an examination of only the most severe problem of insurance coverage -- persons who were completely uninsured all year.

The CPS data on insurance coverage for 1979 to 1986 were analyzed in two ways. (The March CPS actually asks about insurance coverage during the previous calendar year. The CPS has been asking questions about health insurance coverage only since 1980. We therefore used the surveys conducted in 1980 to 1987 to generate estimates of insurance coverage for 1979 to 1986.) First, the data for each year were cross-tabulated to describe relationships between health insurance coverage and various characteristics of the population. The results of these analyses are discussed in the text of the report and presented in the tables in Appendix C; standard errors of estimated percentages are presented in Appendix A. Second, we used regression analysis to describe the *average* changes in health insurance coverage during this period. The regression analyses summarize trends over time by smoothing out year-to-year fluctuations. The results of these regression analyses are presented in Appendix B.

We then graphed the yearly estimates produced by the cross-tabulations and the average trend for these same yearly estimates produced by the regression analyses. These are presented in the figures in the report.

For a more detailed description of the CPS and the regression analyses, please see Appendix A.

---

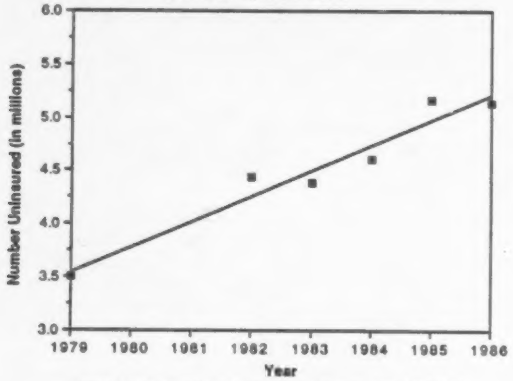
[1] E.R. Brown, R.B. Valdez, H. Morgenstern, T. Bradley, and C. Hafner, *Californians Without Health Insurance: A Report to the California Legislature*, Berkeley: California Policy Seminar, September 1987. The 1977 figure, based on the National Medical Care Expenditure Survey of the National Center for Health Services Research, is from K. Swartz, "Interpreting the Estimates from Four National Surveys of the Number of People Without Health Insurance: A Summary Report," Washington, D.C.: The Urban Institute, April 1985.

The number of Californians who are uninsured increased dramatically between 1979 and 1986

In 1986, 1.6 million more Californians were uninsured than in 1979. During this eight-year period, the number of people without any health insurance coverage -- no private insurance, no Medicare and no Medi-Cal throughout the year -- increased from 3.5 million to more than 5.1 million. Thus, one and one-half times as many Californians were uninsured in 1986 as in 1979.

This dramatic increase is reflected in the steep trend in Figure 1. In the figures, yearly estimates are represented by small squares, and the average trends are represented by a solid line, which fits the annual data to a linear model.[2]

Figure 1. Number of Uninsured Nonelderly Persons, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

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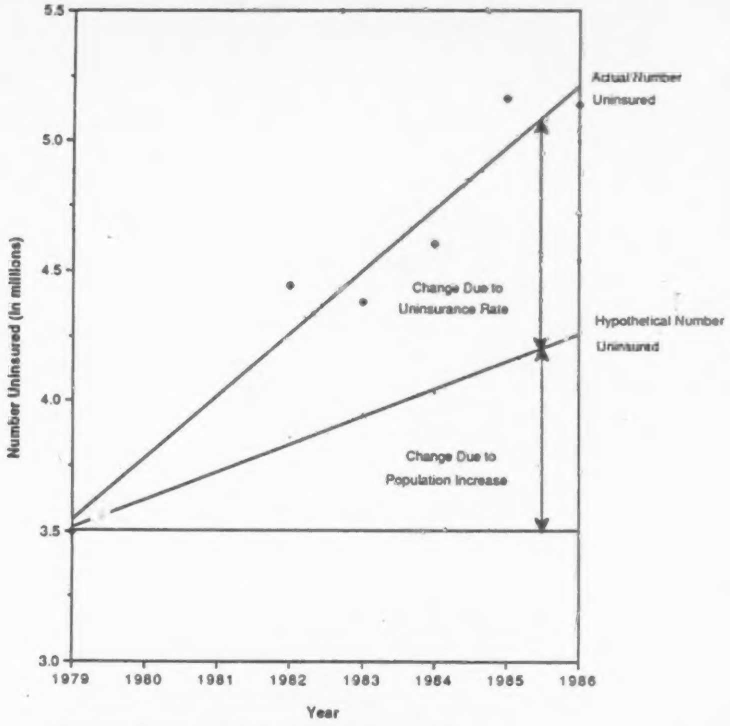
[2] The estimated yearly rates of being uninsured are presented in Tables 1 and 2 in Appendix C.

Half the increase in the number of uninsured was due to rising rate of uninsured

The 1.6 million increase in the number of uninsured people was due partly to the growth in California's population and partly to changes in the proportion of the population who have insurance coverage. In Figure 2, the steeper line reflects the number of people who were actually uninsured during this period, and the line below it represents the growth in the number who would have been uninsured if the rate of insurance coverage (17%) had remained constant at the 1979 level. Thus, the number of uninsured people would have been about 4.3 million if the rate had not changed, a growth of about 800,000 attributable to the increase in population. The difference between these two lines represents the increase in the number of uninsured attributable to the growing *rate* at which people were uninsured -- about 800,000, or one-half the total increase. Thus, we estimate that half the increase in the number of uninsured was due to the growing rate at which people are uninsured.

Figure 2. Components of Change in Number of Uninsured Nonelderly Persons: Actual Number Versus Hypothetical Number of Uninsured If Uninsurance Rate Remained Constant at 17%, California, 1979-1986



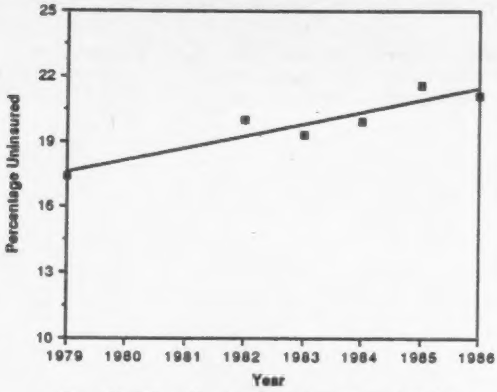
Source: March Current Population Survey data tapes, 1980, 1983-1987

Note: "Actual Number" is the average trend of the number of persons who were uninsured each year; "Hypothetical Number" is the average trend of the number of uninsured persons if the proportion of the nonelderly population who were uninsured had remained constant at the 1979 rate of 17.4%.

The percent of Californians who are uninsured increased considerably between 1979 and 1986

The percentage of the population under 65 years of age who are uninsured rose considerably -- from a low of 17% in 1979 to a high of 22% in 1985 (see Table 1). This increase in the proportion of people who are uninsured is shown in Figure 3.

Figure 3. Percentage of Nonelderly Persons Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

Californians were more likely than other Americans to be uninsured during this period. In 1979, 15% of nonelderly Americans were uninsured (when the rate for Californians was 17%); in 1986, 18% of nonelderly Americans were without insurance (when California's rate was 21%).

Young adults experienced the biggest increase, but children's rates remained high and all age groups were affected

The proportion of children under the age of 6 who were uninsured fluctuated between 19% and 21% from 1979 to 1986 (Figure 4 and Table 1), while the proportion of uninsured children 6-17 years of age increased from 18% to 22% during this same period (Figure 5). The number of uninsured children increased from 1.1 million in 1979 to 1.6 million in 1986.

Figure 4. Percentage of Young Children (0-5 years) Who Were Uninsured, California, 1979-1986

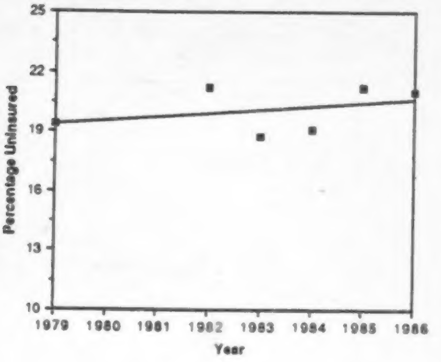
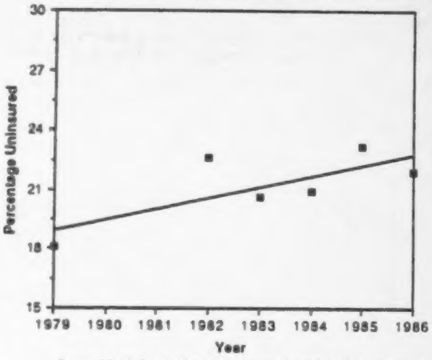


Figure 5. Percentage of Children (6-17 years) Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

Among all age groups, the percentage of young adults (18-29 years of age) without health insurance increased most dramatically -- from 22% in 1979 to 30% in 1986 (see Table 1). The rate at which young adults were uninsured increased steadily during this period, and the linear model closely fits the year-to-year changes (see Figure 6).

The percentages of uninsured adults in each age group also increased: 30-44 years, from 14% to 16% (Figure 7); 45-54 years, 13% to 16% (Figure 8); and 55-64 years, 15% to 18% (Figure 9). The linear model provides a good fit for the year-to-year changes among adults 45-54 years of age, suggesting a linear trend. It is more difficult to identify clear trends among adults 30-44 and 55-64 years of age because the rates fluctuated more from year-to-year, but it is clear that the rates were higher at the end of the period than at the beginning. The total number of uninsured nonelderly adults increased from 2.4 million in 1979 to 3.6 million in 1986.

Figure 6. Percentage of Young Adults (18-29 years) Who Were Uninsured, California, 1979-1986

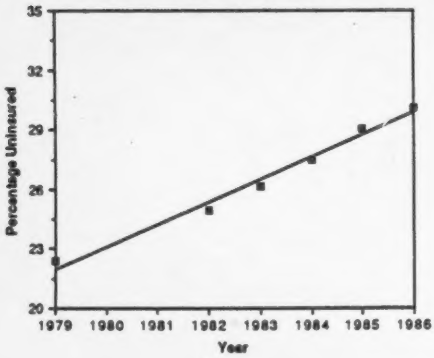


Figure 7. Percentage of Adults (30-44 Years) Who Were Uninsured, California, 1979-1986

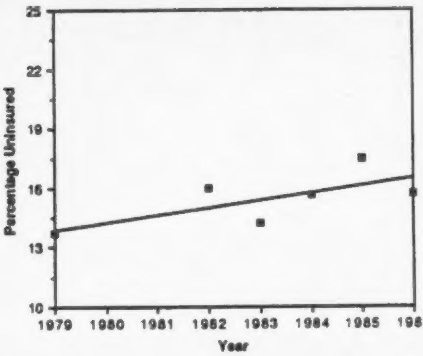


Figure 8. Percentage of Adults (45-54 Years) Who Were Uninsured, California, 1979-1986

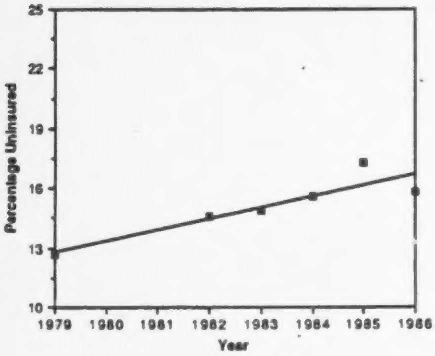
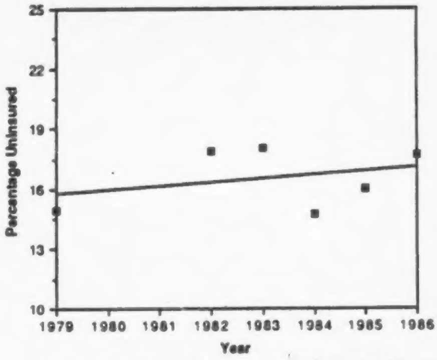


Figure 9. Percentage of Adults (55-64 Years) Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

The proportion of near-poor who are uninsured has increased dramatically

Near-poor children (those living in families with incomes between the federal poverty level and 150% of poverty) experienced a massive increase in the percentage who were uninsured, from 27% in 1979 to 40% in 1986 (see Table 1 and Figure 11).

The probability of being uninsured did not change appreciably over this period for children in other income groups. The rate for poor children (with family incomes below the federal poverty level) hovered around 33% (Figure 10). For lower-middle-income children (with family incomes between 150% and 299% of the poverty level), it fluctuated around 21% (Figure 12). And for more-affluent children (with family incomes at least three times the poverty level), it fluctuated around 9% (Figure 13).

During this period, the number of uninsured poor and near-poor children increased dramatically from 493,000 in 1979 (44% of all uninsured children) to 877,000 in 1986 (56% of all uninsured children). Part of this increase in the number of uninsured low-income children is due to the steep increase in the *rate* at which near-poor children were uninsured (27% to 40%), and part of the increase is due to the dramatic increase in the percentage of children living in poverty (from 16% in 1979 to 23% in 1986).

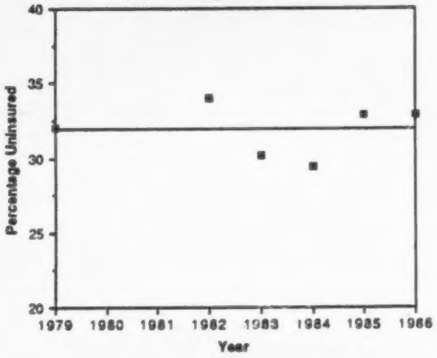


Figure 10. Percentage of Children With Family Income Below Poverty Who Were Uninsured, California, 1979-1986

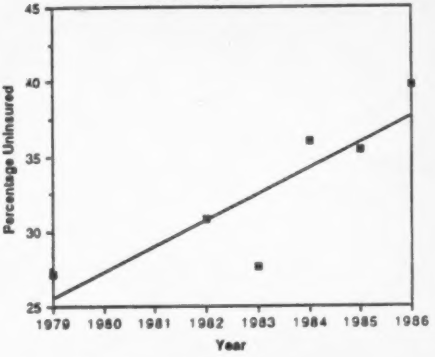


Figure 11. Percentage of Children With Family Income 100%-149% of Poverty Who Were Uninsured, California, 1979-1986

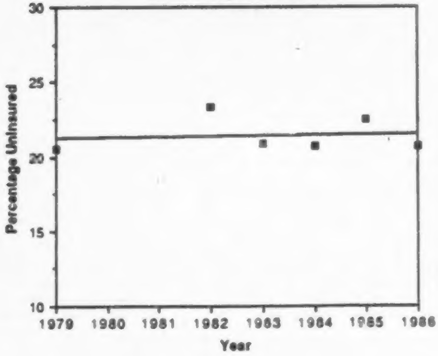


Figure 12. Percentage of Children With Family Income 150-299% of Poverty Who Were Uninsured, California, 1979-1980

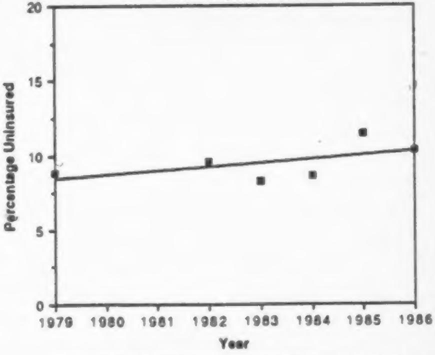


Figure 13. Percentage of Children With Family Income Above 300% of Poverty Who Were Uninsured, California, 1979-1986

Source: March Current Population Survey data tapes, 1980, 1983-1987

The percentage of uninsured adults increased among all income groups between 1979 and 1986, but the increase for the near-poor was the most dramatic -- from 29% in 1979 to 39% in 1986 (see Table 1). The linear model fit the annual estimates well for near-poor adults (Figure 15).

The proportion of uninsured adults in other income groups also increased during this period, but not as sharply as the rates for the near-poor. The proportion of uninsured poor adults increased substantially (Figure 14), from 41% in 1979 to 46% in 1986, down slightly from the high of 48% in 1985. The proportion of uninsured adults with family incomes between 150% and 299% of poverty also rose substantially (Figure 16), from 22% in 1979 to 27% in 1986. The percentage of uninsured adults with family incomes at least 300% of poverty increased very slightly over this period (Figure 17), from 9% to 11%.

The number of uninsured poor and near-poor adults increased from 812,000 (34% of all uninsured adults) in 1979 to 1,427,000 (40% of all uninsured adults) in 1986.

However, a large proportion of the uninsured are not poor at all: 27% of all uninsured Californians (1,389,000) had family incomes at least three times the poverty level in 1986 -- approximately $35,000 for a family of four.

Figure 14. Percentage of Adults With Family Income Below Poverty Who Were Uninsured, California, 1979-1986

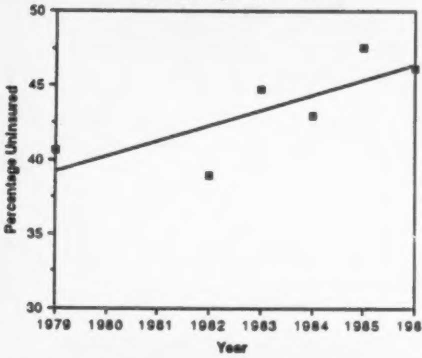


Figure 15. Percentage of Adults With Family Income 100%-149% of Poverty Who Were Uninsured, California, 1979-1986

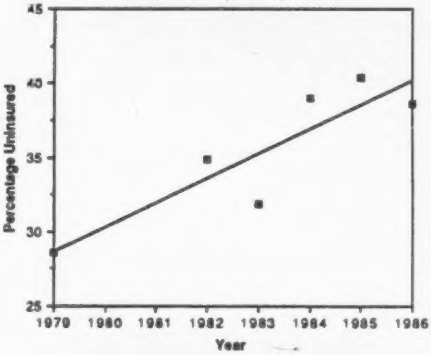


Figure 16. Percentage of Adults With Family Income 150%-299% of Poverty Who Were Uninsured, California, 1979-1986

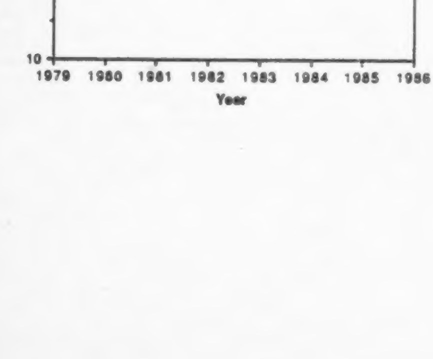
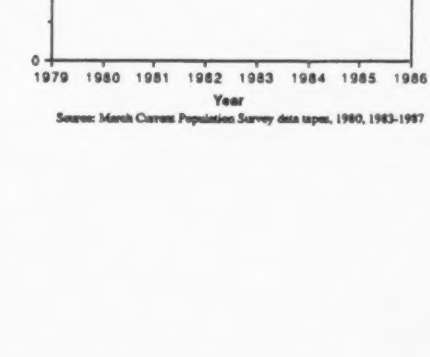


Figure 17. Percentage of Adults With Family Income Above 300% of Poverty Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

Latino children and adults experienced startling increases

The percentage of Latino children who were uninsured increased substantially from their already high level of 23% in 1979 to 33% in 1986 (Figure 20), the highest level among all ethnic groups (see Table 1).

The proportion of uninsured black children increased at the end of this period (Figure 19), from 19% in 1979 to 20% in 1985 and then to 29% in 1986, which may indicate a dramatic change in the trend, a one-year anomaly, or sampling error. The uninsured rates of other ethnic groups fluctuated from year-to-year, even for those groups with apparent increasing trends. The uninsured rate for non-Latino white children hovered around 16% (Figure 18), and the rate for Asian children and those in other ethnic groups fluctuated around 20%-21%, with a one-year jump to 23% in 1985 and a drop to 13% the next year (Figure 21).

Figure 18. Percentage of Non-Latino White Children Who Were Uninsured, California, 1979-1986

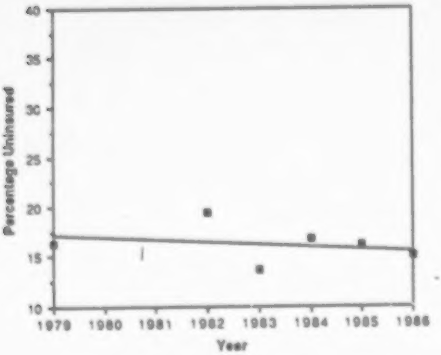


Figure 19. Percentage of Black Children Who Were Uninsured, California, 1979-1986

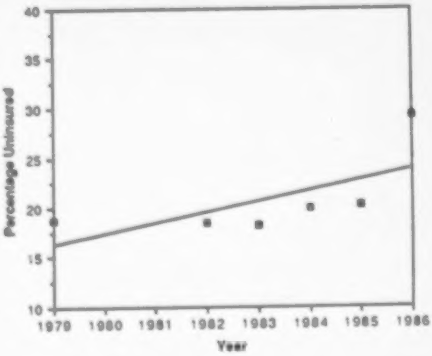


Figure 20. Percentage of Latino Children Who Were Uninsured, California, 1979-1986

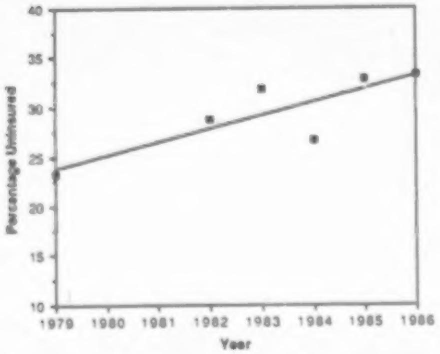
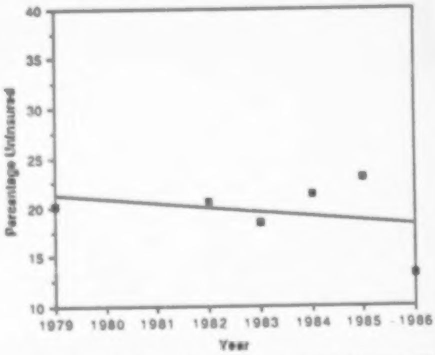


Figure 21. Percentage of Asian & Other Children Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

The proportion of Latino adults who are uninsured increased dramatically from 24% in 1979 to 37% in 1986 (Figure 24). The rates for Latino adults were substantially higher than the rates for other ethnic groups during this period; no other ethnic group showed such a steep and consistent increase over this eight-year period (see Table 1).

Non-Latino whites consistently have had the lowest rates of being uninsured among all ethnic groups, and their rates of 15%-16% did not change appreciably between 1979 and 1986 (Figure 22), although their rates in California have averaged about two percentage points higher than for the U.S. as a whole. Black adults, whose probability of being uninsured has generally been higher than that for non-Latino whites, showed a sudden jump to 25% in 1986 (Figure 23), but, as with black children, it is uncertain whether this represents a change in the trend, a one-year fluctuation, or sampling error. The percentage of uninsured Asian and other ethnic group adults showed no appreciable change in this period, remaining mainly around 19%-20% (Figure 25).

Figure 22. Percentage of Non-Latino White Adults Who Were Uninsured, California, 1979-1986

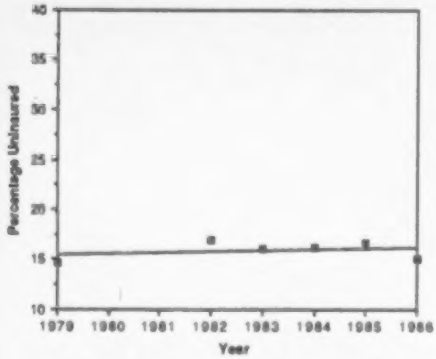


Figure 23. Percentage of Black Adults Who Were Uninsured, California, 1979-1986

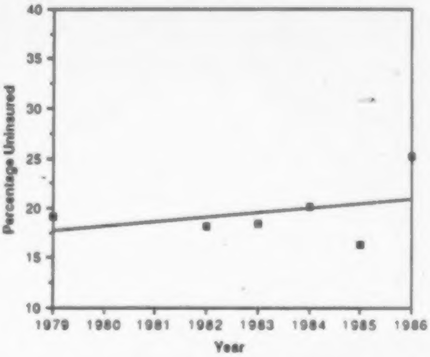


Figure 24. Percentage of Latino Adults Who Were Uninsured, California, 1979-1986

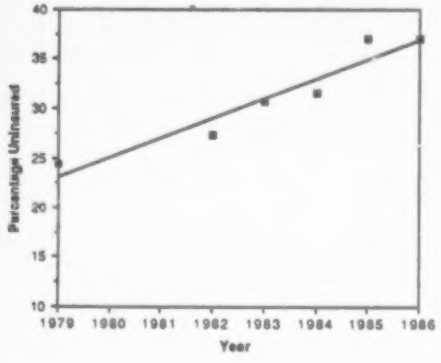
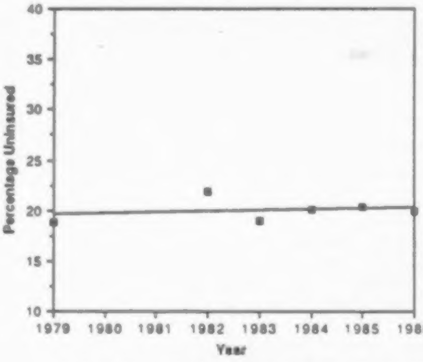


Figure 25. Percentage of Asian & Other Adults Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

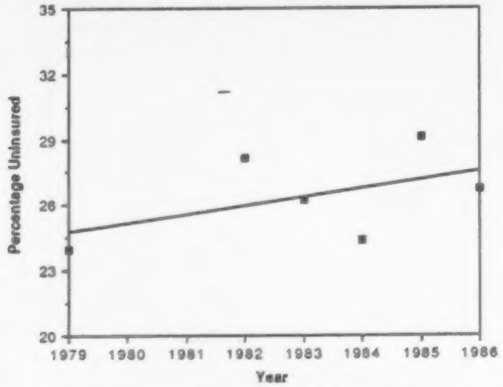
The lack of health insurance is clearly a problem that affects all ethnic groups. The ranks of the uninsured under the age of 65 include 2.2 million non-Latino whites, 2.1 million Latinos, more than 400,000 blacks, and more than 400,000 Asians and members of other ethnic groups.

Adults who are not in the labor force were slightly more likely to be uninsured in 1986

Among adults (16-64 years of age) who did not work throughout the year, a large percentage were uninsured, but their rate was only somewhat higher in 1986 (27%) than in 1979 (24%). The uninsured rates for this group rose after 1979, fell after 1982, and rose again in 1985 (see Table 2). The trend is not well represented by the linear model (Figure 26).

The proportion of uninsured was higher in 1986 than in 1979 among several subgroups of people not in the labor force -- especially among those who were unemployed, ill or disabled, homemakers, and students -- but these changes were fairly small and fluctuated substantially between 1982 and 1985.

Figure 26. Percentage of Persons (Age 16-64) Not in Labor Force Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

These groups together represented 20% of the uninsured in 1986, and they included 374,000 homemakers, 326,000 students, 114,000 ill and disabled people, 76,000 persons who were unemployed all year, and 60,000 retired adults.

The proportion of workers who are uninsured increased

The number of Californians (16-64 years of age) who work for a living but have no health insurance coverage rose from 1.7 million in 1979 to 2.7 million in 1986. This growth of 1 million uninsured workers represented an increase from 15% of all workers in 1979 to 20% of all workers in 1986 (Figure 27 and Table 2).

Throughout this period, California's rates were higher than for the U.S. as a whole. For example, 12% of U.S. workers were uninsured in 1979, compared with 15% for California, and 15% of U.S. workers in 1986 were uninsured, compared with 20% for California.

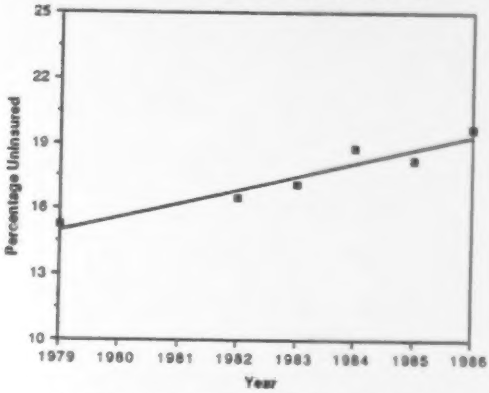


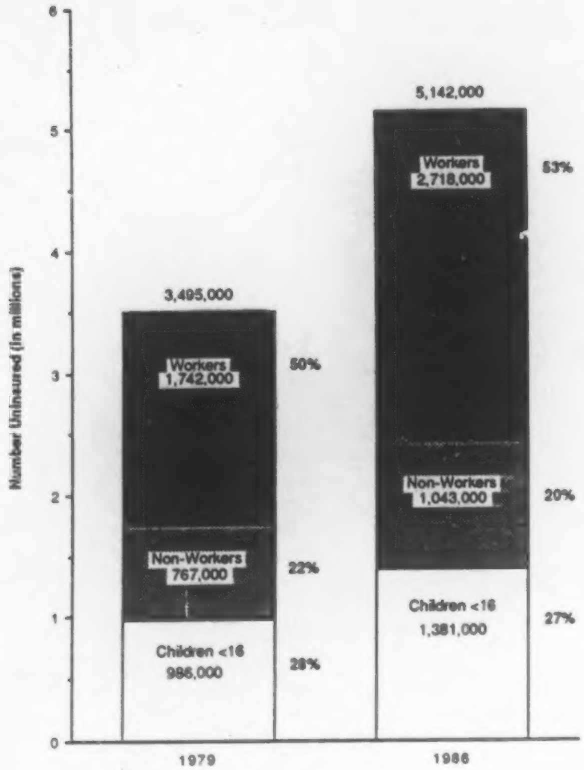
Figure 27. Percentage of Workers (Age 16-64) Who Were Uninsured, California, 1979-1986

Source: March Current Population Survey data tapes, 1980, 1983-1987

Working people have become a larger proportion of the uninsured

Working people comprise more than half the uninsured. The number of uninsured workers has grown faster than the number of uninsured persons not in the labor force and faster than the number of uninsured children, so that uninsured workers now represent a somewhat larger share of the uninsured than they did in 1979. In 1986, uninsured workers (16-64 years of age) represented 53% of the uninsured population, compared with 50% in 1979; nonworking adults (16-64 years of age) represented 20% of the uninsured, compared with 22% in 1979; and children under 16 years of age represented 27%, down slightly from their 28% share in 1979 (Figure 28).

Figure 28. Number and Percent of Nonelderly Uninsured Persons By Labor Force Participation in 1979 and 1986, California



Source: March Current Population Survey data tapes, 1980, 1987

The uninsured rate rose among the self-employed and private-sector employees

The proportion of self-employed workers who were uninsured increased sharply between 1979 and 1986, from 30% to 37%, after peaking at 39% in 1984 (Table 2). The number of self-employed workers reached 410,000 in 1986. The early trend in this period is clearly upward, although there may be a downward trend in the last two years (Figure 29).

The percentage of employees of private-sector firms who were uninsured increased steadily from 15% in 1979 to 20% in 1986, an increase of nearly 868,000 during this eight-year period, a trend for which the linear model provides a good fit (Figure 30). Private-sector employees accounted for 2.2 million of the uninsured, 43% of all uninsured people in California.

The proportion of government employees who were uninsured hovered between 6%-8% from 1979 to 1986, with some year-to-year fluctuations after 1983 (Figure 31).

Figure 29. Percentage of Self-Employed Persons Who Were Uninsured, California, 1979-1986

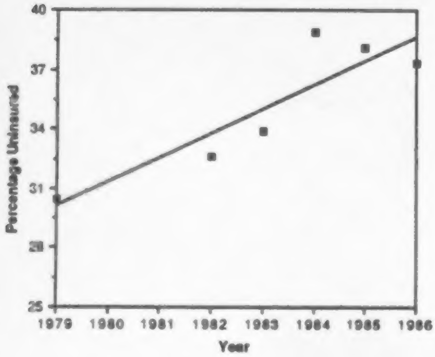


Figure 30. Percentage of Private-Sector Employees Who Were Uninsured, California, 1979-1986

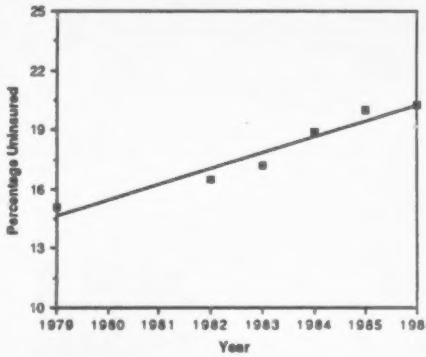
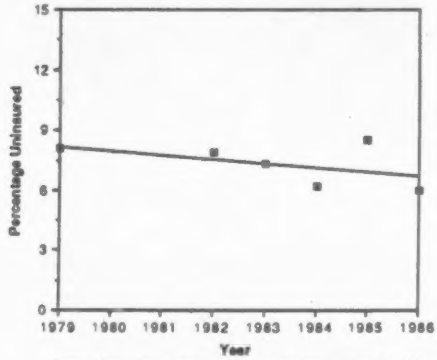


Figure 31. Percentage of Government Employees Who Were Uninsured, California, 1979-1986



Source: March Current Population Survey data tapes, 1980, 1983-1987

The proportion of uninsured full- and part-time employees increased

The probability of being uninsured increased sharply among full-time and part-time employees between 1979 and 1986 (Table 2). Among full-time full-year employees (those who worked at least 35 hours a week for at least 50 weeks a year), the proportion who have no health insurance rose from 9% in 1979 to 12% in 1986 (Figure 32). The number of uninsured increased from 505,000 in 1979 to 981,000 in 1986.

Among full-time part-year employees (those who worked less than 50 weeks), the proportion of uninsured increased from 21% to 28%, an increase of 166,000 between 1979 and 1986 (Figure 33).

The percentage of part-time employees who are uninsured rose from 19% in 1979 to 24% in 1986 after peaking at 29% in 1985, an increase of 187,000 between 1979 and 1986 (Figure 34).

Figure 32. Percentage of Full-Time, Full-Year Employees Who Were Uninsured, California, 1979-1986

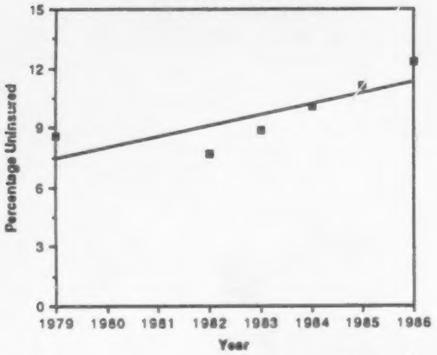


Figure 33. Percentage of Full-Time, Part-Year Employees Who Were Uninsured, California, 1979-1986

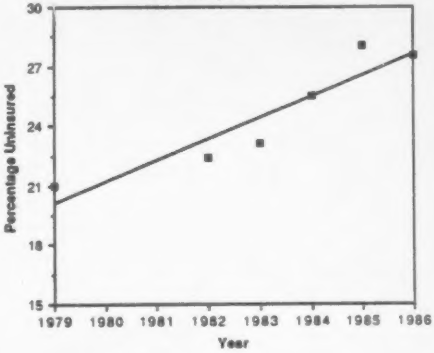
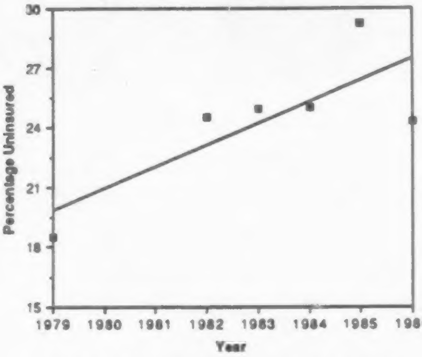


Figure 34. Percentage of Part-Time Employees Who Were Uninsured, California, 1979-1986



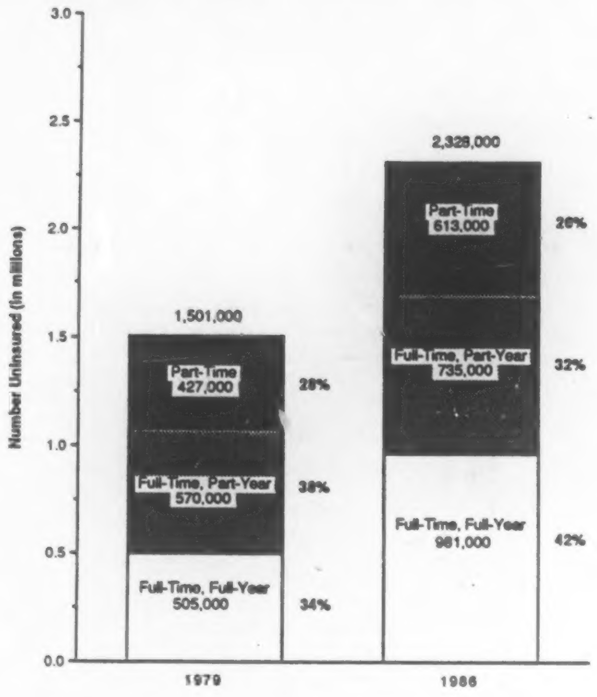
Source: March Current Population Survey data tapes, 1980, 1983-1987

The rate of uninsurance among low-income full-time employees is far worse than for more-affluent employees. Among all full-time (part-year and full-year) employees in California in 1986, 48% of those with family incomes below 150% of the poverty level were uninsured compared to 12% of those with family incomes above that level.

Full-time full-year employees are now a larger share of all uninsured employees

In 1986, uninsured full-time full-year employees represented 42% of all uninsured employees, up from 34% in 1979 (Figure 35). Because they represent such a large share of the workforce and the population, the relatively small increase in the proportion of uninsured full-time full-year employees has had a very large impact on the total number of uninsured in the state, adding 476,000 to the ranks of the uninsured between 1979 and 1986 and increasing their proportion of all uninsured employees. Of course, the numbers of uninsured full-time part-year employees and uninsured part-time employees also grew, but in 1986 they represented somewhat smaller shares of all uninsured employees.

Figure 35. Number and Percent of Uninsured Employees by Full- & Part-Time Employment in 1979 & 1986, California



Source: March Current Population Survey data tapes, 1980, 1987

The proportion of employees with health insurance as a fringe benefit has fallen

For full-time employees, the increases in the proportion who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers (Table 3). The percentage of full-time full-year employees who received health insurance as a fringe benefit rose from 78% in 1979 to 83% in 1982 and then fell to 75% by 1986 (Figure 36).[3] During this same period, the percentage of full-time part-year employees with this fringe benefit was about one-third lower than for full-year employees; it increased from 51% in 1979 to 53% in 1981 and then decreased to 45% by 1986 (Figure 37).

The percentage of part-time employees who received health care benefits through their jobs rose from 21% in 1979 to 25% in 1982 and fell back to 21% by 1986.

Figure 36. Percentage of Full-Time, Full-Year Employees With Health Insurance As Fringe Benefit, California, 1979-1986

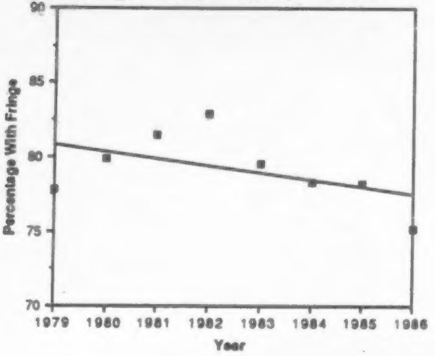


Figure 37. Percentage of Full-Time, Part-Year Employees With Health Insurance As Fringe Benefit, California, 1979-1986

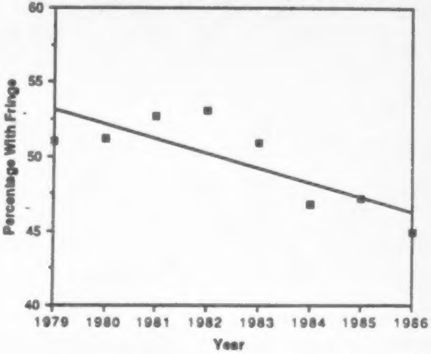
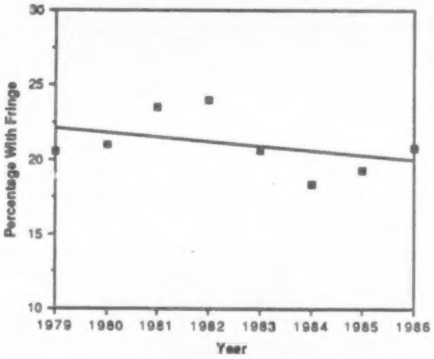


Figure 38. Percentage of Part-Time Employees With Health Insurance as Fringe Benefit, California, 1979-1986



Source: March Current Population Survey data tapes, 1980-1987

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[3] The CPS provides data for *all* years (1979-1986) for employees who received health insurance as a fringe benefit.

At this time, we can only speculate about *why* the percentage of employees with health insurance as a fringe benefit rose as California and the nation entered the deep recession of the early 1980s. It is likely that, as many full-time workers lost their jobs, those who kept their jobs were more likely to be employees who were already covered by this benefit -- explaining why the percent of full-time employees with this benefit increased.[4] As the recession deepened, the number of full-time employees who worked less than a full year increased.[5] Many of these people may have had health insurance on their jobs before being laid off or changing to less than full-year employment. Alternatively, these full-time part-year employees could have had this fringe benefit for just part of the year in which they worked full-time, but the Current Population Survey would count them simply as getting the fringe benefit, without respect to the period of time during which they had it or which job provided it.

Other full-time workers may have accepted part-time work, either after being laid off or as an alternative to lay offs.[6] Again, some of these part-time workers may have received health insurance as a fringe benefit on the jobs at which they had worked full-time during an earlier part of the year.[7] In addition, however, many workers may be taking jobs that do not provide health insurance, particularly new jobs created this decade in the service and retail private sectors of the economy.[8]

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[4] The total number of full-time full-year employees in California rose by 470,000 between 1979 and 1980, but rose by only 3,000 in 1981, and fell by only 47,000 in 1982. After 1982, the size of this important economic group began to recover with an increase of 389,000 in 1983, an increase of 324,000 in 1984, 427,000 in 1985, and 459,000 in 1986.

[5] The number of full-time part-year employees decreased by 39,000 between 1979 and 1980, then increased each of the next two years -- by 36,000 and 42,000, respectively -- then fell by 297,000 in 1983, then increased by 61,000 in 1984, increased by 182,000 in 1985, and decreased by 54,000 in 1986. Full-time part-year employees declined from 24% of the adult workforce in 1981 and 1982 to 21% in 1983 to 1985 and to 20% in 1986.

[6] The number of part-time employees increased by 178,000 between 1979 and 1980, increased another 75,000 in 1981 and 75,000 in 1982, and then fell by 79,000 in 1983, increased by 101,000 in 1984, and fell by 6,000 in 1985 and by 121,000 in 1986. Part-time employees increased from 20% of all adult employees in 1979 and 1981 to 21% in 1981 to 1984 and declined to 20% in 1985 and to 18% in 1986.

[7] The Current Population Survey would have counted them as part-time employees if they worked more of the year at less than 35 hours a week than they worked full-time. If they received health insurance on a full-time job for even part of the year, they would have been counted as insured. Moreover, some formerly full-time employees may have had their hours reduced below 35 per week as business activity dropped, but they may have retained their health insurance fringe benefit during their sojourn as part-timers.

[8] B. Bluestone, and B. Harrison, *The Great American Job Machine: The Proliferation of Low Wage Employment in the U.S. Economy*, Study Prepared for Joint Economic Committee of U.S. Congress, December 1986. See also R.L. Dillon, *The Changing Labor Market: Contingent Workers and the Self-Employed in California*, Sacramento: Senate Office of Research, July 1987.

The proportion of employees with fringe benefit is lower among service, retail, construction and agricultural employees

The proportion of employees who received health insurance as a fringe benefit is much lower in some industries than in others. Among full-time full-year employees, the proportion with this fringe benefit was lower in the personal services sector (41%), agriculture, forestry and fisheries (44%), the retail sector (61%), and construction (66%) than in, for example, transportation (81%), professions (81%), and durable goods manufacturing (86%). The percentage of full-time part-year employees with health insurance as a fringe benefit is also lower among these same industries -- agriculture, forestry and fisheries employees (11%), construction employees (35%), retail employees (36%), and personal services employees (23%) -- but they are joined by business and repair services employees (36%). (Insurance coverage by industry is not shown in Table 3 because it would require a very large number of data points.)

Part-time employees are, of course, much less likely to get health insurance as a fringe benefit. Among part-time employees (which includes those working 34 hours a week as well as those working 5 or 10 hours a week), some were more likely to receive this fringe benefit (for example, employees in finance, 34%; professions, 31%; and durable goods manufacturing, 27%) than were others (for example, employees in construction, 14%; wholesale, 11%; service industries, 10%; and agricultural industries, 5%).

The proportion of employees with fringe benefit declined in some industries

The proportion of employees who received health insurance through their jobs declined in some industries, but the trends varied among full- and part-year full-time employees and part-time employees.

In durable goods manufacturing, a heavily unionized economic sector with relatively higher pay and more benefits, the rate at which full-time employees (both full-year and part-year) received health insurance did not change much over these eight years, while the rate for part-time employees increased for three years and then declined, rose again and fell again (Figure 39).

In nondurable goods manufacturing, which is less unionized and on average pays less and provides fewer benefits, the proportion of employees who received this fringe benefit declined among full-time full-year workers after 1981, while the rates for full-time part-year and part-time employees show a weak downward trend that fluctuated during the entire period (Figure 40).

Among construction employees, the proportion of full-time full-year workers with health insurance as a fringe benefit increased each year for three years and then decreased each of the next four years (Figure 41). The rates for full-time part-year and part-time employees declined more steadily over the eight-year period, although the rates fluctuated considerably.

In the retail sector, full-time full-year employees have experienced a decline in the proportion who receive health insurance through their jobs, a trend that is well described by the linear model (Figure 42). The rates for full-time part-year and part-time employees fluctuated yearly, but did not reflect a clearly decreasing trend.

Among service-sector employees, including those in business and repair services as well as those in personal services, the rates remained low throughout the eight-year period with relatively minor yearly fluctuations (Figure 43). This pattern applied to all three groupings of full- and part-time employees.

Full-time agricultural, forestry and fisheries employees (both full-year and seasonal) experienced sharp declines in their health insurance fringe benefits, although with some fluctuation from year-to-year (Figure 44). The rate for part-time employees remained very low.

Figure 39. Percentage of Durable Goods Manufacturing Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986

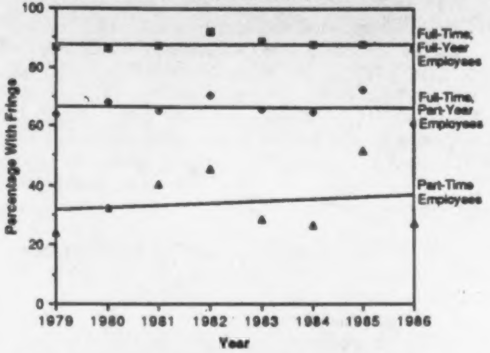


Figure 40. Percentage of Nondurable Goods Manufacturing Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986

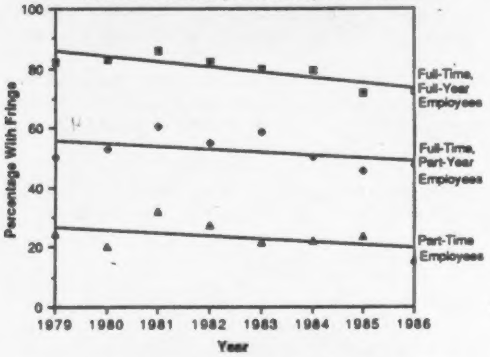
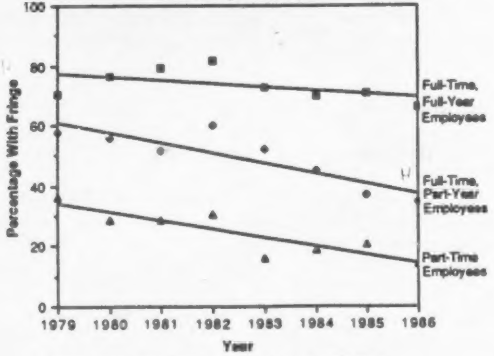


Figure 41. Percentage of Construction Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986



Source: March Current Population Survey data tapes, 1980-1987

Figure 42. Percentage of Retail Employees With Health Insurance As Fringe Benefit, Full- & Part-Time, California, 1979-1986

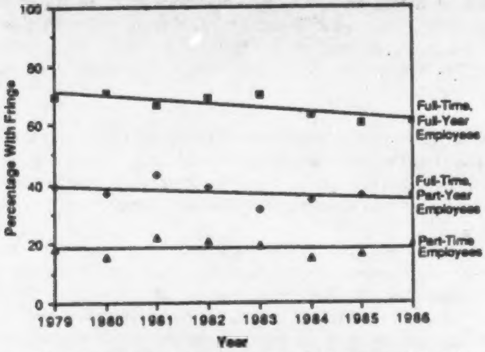


Figure 43. Percentage of Business, Repair & Personal Services Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986

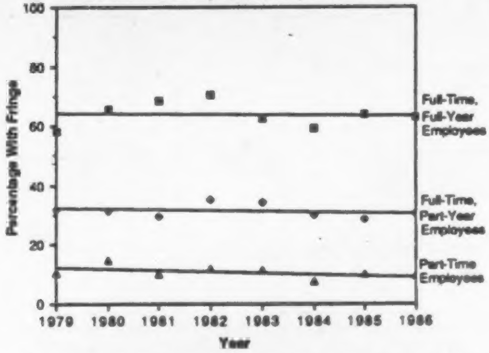
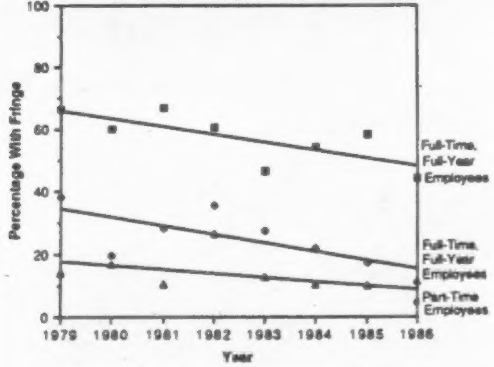


Figure 44. Percentage of Agricultural, Forestry & Fishing Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986



Source: March Current Population Survey data tapes, 1980-1987

Latino employees experienced the biggest drop in health benefits

The percentage of Latino employees who received health insurance as a fringe benefit fell most dramatically from 53% to 46% between 1979 and 1986 (Table 3). Asian employees and those in other ethnic groups also experienced a decline in this benefit, from 61% to 57%. The rate for black employees fluctuated between 58% and 66%, but without any clear trend. Non-Latino white employees also showed essentially no change, remaining around 63%.

When we look at the changes over time within each ethnic group, controlling for whether employees are full- or part-time, it is clear that the strongest downward trends are among full-time Latino employees. For them, the proportions of full-time, full- and part-year employees who received health benefits fell fairly steadily (Figure 47). The rate for Latino part-time employees did not change much over this period.

Despite minor year-to-year changes for non-Latino white employees, there is essentially no change in this group's three employee categories (Figure 45). For black employees, a weak linear downward trend is identified only for full-time part-year employees, but all three groupings showed considerable fluctuations (Figure 46). Changes were small and inconsistent among Asian employees and those in other ethnic groups for all employment categories, resulting in trends that were not well described by linear models (Figure 48).

Figure 45. Percentage of Non-Latino White Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986

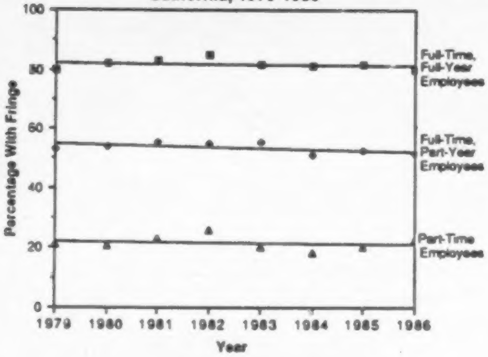


Figure 46. Percentage of Black Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986

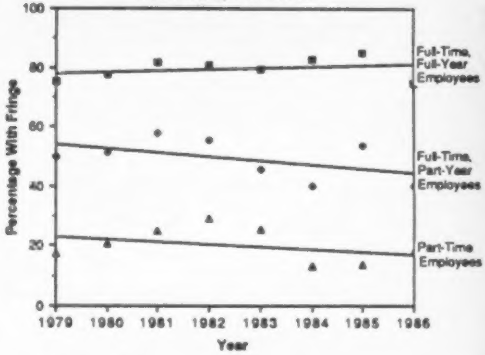


Figure 47. Percentage of Latino Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986

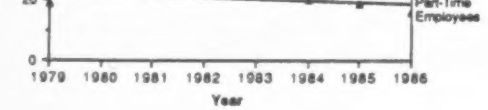
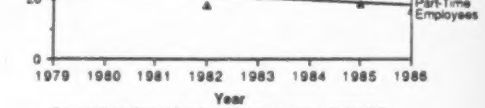


Figure 48. Percentage of Asian & Other Employees With Health Insurance as Fringe Benefit, Full- & Part-Time, California, 1979-1986



Source: March Current Population Survey data tapes, 1980-1987

The decreasing proportions of Latino employees and those in other ethnic groups who receive health insurance as a fringe benefit are not accounted for by shifts in the labor force from full-year to part-year or full-time to part-time employment. In fact, among Latino employees a greater proportion worked full-time for the full year in 1986 (59%) than in 1979 (50%), and a smaller proportion worked full-time for part of the year (25% in 1986 compared to 34% in 1979). Part-time employees did not change as a proportion of all Latino employees (16% in both 1979 and 1986). Similar trends were found among other ethnic groups as well.

Summary and Discussion

Summary

The number of Californians who are uninsured increased by more than 50%, from 3.5 million in 1979 to 5.1 million in 1986. We estimate that about half this increase was due to growth in California's population and half to a rising rate at which people were uninsured. In 1979, 17% of nonelderly Californians were uninsured all year, but by 1985, the rate reached 22%.

Lack of insurance coverage has increased among all age groups, but was steepest for young adults, followed by children 6-17 years of age and adults 45-54 years of age.

Near-poor children and adults (those with family incomes between 100% and 150% of the federal poverty level) suffered severe deterioration in their health insurance coverage. Poor adults (with family incomes below poverty), lower-moderate-income adults (with family incomes between 150% and 299% of the poverty level), and more-affluent children and adults (with family incomes of at least 300% of the poverty level) all experienced decreased rates of insurance coverage. A large proportion of the uninsured are not poor at all: one-fourth had family incomes at least three times the poverty level in 1986.

Latino children and adults sustained dramatic decreases in their health insurance coverage. Rates for other ethnic groups fluctuated without showing clearly increasing or decreasing trends, although data for black children and adults showed substantial jumps in the proportions of uninsured in 1986.

Among adults (16-64 years of age) who did not work throughout the year -- including homemakers, students, and those who were retired, ill, or unemployed all year -- one-fourth were uninsured, but their rate was only somewhat higher in 1986 than in 1979.

The proportion of workers who are uninsured increased from 15% in 1979 to 20% in 1986, a rate that was one-third higher than for the U.S. as a whole. Working people comprise more than half the uninsured. The proportion of private-sector employees and self-employed workers who were uninsured increased sharply between 1979 and 1986. The probability of being uninsured increased sharply among both full-time and part-time employees between 1979 and 1986.

For full-time employees, the increases in the proportion who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers.

The proportion of employees with health insurance as a fringe benefit is lower among service, retail, construction and agricultural employees. Latino employees experienced the biggest drop in this fringe benefit.

Why is the growing lack of health insurance a problem?

The uninsured have less access to care. Compared to people with health insurance coverage, the uninsured have much less access to necessary medical care. A 1977 study by the U.S. National Center for Health Services Research found that insured persons under age 65 averaged 3.7 physician visits per year, 54% more than the average of 2.4 per year for people without insurance. Furthermore, this difference in use of health services does not seem to be due only to differences in health status between the insured and the uninsured since, among people who were in fair or poor health, the insured averaged 68% more physician visits per year than did the uninsured (see table below). They also found that insured people received 91% more days of hospitalization.

Similarly, a 1986 study by the Robert Wood Johnson Foundation found that, compared to insured people, uninsured persons were less likely to see a physician in a 12-month period, less likely to get their young children adequately immunized, less likely to receive prenatal care in the first trimester of pregnancy, less likely to have their blood pressure checked, and less likely to see a physician if they had serious symptoms (see table below).

Less Access to Health Care

	Insured	Uninsured
Average physician visits per year (1977)	3.7	2.4
Average physician visits per year among people in fair or poor health (1977)	6.9	4.1
Percent with physician visit in a year (1986)	68%	59%
Percent young children with adequate immunizations (1986)	94%	81%
Percent pregnant women with prenatal care in first trimester (1986)	85%	80%
Percent of persons with blood pressure check in a year (1986)	60%	50%
Percent with serious symptoms who saw physician in 30 days (1986)	61%	32%

Source: (1977 data) K. Davis, D. Rowland, "Uninsured and Underserved: Inequities in Health Care in the United States," *Milbank Memorial Fund Quarterly*, 1983, *61*:149-176; (1986 data) H.E. Freeman, "Americans Report on Their Access to Health Care: The 1986 Robert Wood Johnson Foundation Survey," Institute for Social Science Research, University of California, Los Angeles, May 1987.

Access for the uninsured has deteriorated. Not only do the uninsured have less access to care; their access has been declining during the 1980s. The Robert Wood Johnson Foundation study found substantial deterioration in the access to care of all Americans between their survey in 1986 and an earlier one in 1982. In that four-year period, the percent of the uninsured with a regular source of care and those who saw a physician within a year declined 13%, and the average number of physician visits per uninsured person fell 16% (see table below).

Changes in Access to Health Care, 1982-1986

Uninsured Population	1982	1986	Percent Change
Percent with regular source of care	79%	69%	-13%
Percent who saw physician in past year	68%	59%	-13%
Average number of physician visits in year	3.8	3.2	-16%

Source: H.E. Freeman, "Americans Report on Their Access to Health Care: The 1986 Robert Wood Johnson Foundation Survey," Institute for Social Science Research, University of California, Los Angeles, May 1987; and H.E. Freeman et al., "Americans Report on Their Access to Health Care," *Health Affairs*, 1987, *6*:6-18.

Less access, poorer health. The little research that has been conducted on the impact on people's health of being uninsured suggests that reduced access to medical care due to lack of insurance coverage may contribute to the worsening of health status, especially among persons with chronic illnesses. For example, a study at the UCLA Medical Center found that loss of Medi-Cal coverage had a serious adverse impact on the health status of patients with diabetes and high blood pressure.[9]

Everyone pays for care to the uninsured. Lack of health insurance also creates financial burdens on health care providers and government. The growing numbers of uninsured people are reflected in the mounting financial pressures county hospitals, many nonprofit hospitals, and community clinics experience from uncompensated care they provide. Although reliable estimates of the charity care provided by community clinics and private doctors have not been developed, the burden on hospitals has been well documented.

Uncompensated care (bad debts and charity care) cost California's hospitals $827 million in fiscal year 1984-85, up from $531 million in 1981-82. In inflation-adjusted dollars, uncompensated care increased 27% in just three years. Providing for the most essential health care needs of the medically indigent -- low-income uninsured people -- adds to the fiscal difficulties of the counties and the state. California's county hospitals in fiscal year 1984-85 reported $345 million in uncompensated care, 41% of the total for all hospitals in the state and three and one-half times their share of all hospital beds.[10] This problem is likely to worsen as the number of AIDS patients, including those who are medically indigent, increases during the next few years. Taxpayers shoulder the financial burden of uncompensated care provided by county hospitals.

Private hospitals provided the other 59% of uncompensated care ($481 million) in 1984-85. Private hospitals shifted the costs of much of their uncompensated care to privately insured patients and their employers, who pay most of their health insurance premiums. But as cost-shifting has become more difficult over the last few years, more and more private hospitals have closed their trauma centers and shut their doors to rescue ambulances in an effort to decrease their financial burdens resulting from uninsured patients.

Public spending for the medically indigent has fallen

Providing for the health care needs of uninsured low-income people (the "medically indigent") is a state responsibility which the state shares with the counties.[11] It is therefore important to understand how state and county spending has changed over time in relation to changes in the number of uninsured low-income people. Because the transfer of "medically indigent adults" from the Medi-Cal program to county responsibility on January 1, 1983 significantly changed this state-county relationship and because the Current Population Survey is not sufficiently sensitive to accurately measure even changes as large as the sudden loss of Medi-Cal by 250,000 people, we will consider only changes in state and county indigent medical care expenditures (the medical care "safety net") from 1983 to 1986.

In 1983, state and county programs spent $911 million on medical care to this population. If we consider the 2,077,000 persons who were uninsured and had family incomes below 150% of the poverty level as the "medically indigent" target population, then California spent an average of $439 per medically indigent person in that year.[12] In 1986, the state and counties spent a total of $1,112 million on this population, which had grown to 2,304,000 -- an average of $483 per medically indigent person.[13] After adjusting for inflation, total spending increased less than 1% during these three years, but because of the increasing poor and near-poor uninsured population, *spending per medically indigent person fell 9%.*[14]

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[9] N. Lurie, N.B. Ward, M.F. Shapiro, and R.H. Brook, "Termination from Medi-Cal: Does It Affect Health?" New England Journal of Medicine, 1984, 311:480-484; and N. Lurie, N.B. Ward, M.F. Shapiro, C. Gallego, R. Vaghaiwalla, and R.H. Brook, "Termination of Medi-Cal Benefits: A Follow-up Study One Year Later," New England Journal of Medicine, 1986, 314:1266-1268.

[10] T.G. Rundall, S. Sofaer, and W. Lambert, "Uncompensated Hospital Care in California: Private and Public Hospital Responses to Competitive Market Forces," presented at American Public Health Association annual meeting, New Orleans, October 21, 1987. The authors analyzed data from the Office of Statewide Health Planning and Development.

[11] The state delegates this responsibility to the counties under the Welfare and Institutions Code Section 17000, but the state provides the counties with most of the funds required to carry out this mandate.

[12] Of the 4.4 million uninsured nonelderly people in California in 1983, 2.077 million of them had family incomes below 150% of poverty. In the 1983-84 fiscal year, the state spent $476.3 million on the Medically

Need for public policy action

The number of uninsured Californians and the proportion of the nonelderly population who are uninsured have increased dramatically. Rapidly rising proportions of children, young adults, lower-income and minority Californians, full-time and part-time workers, and even many more affluent families and individuals have no protection against health care expenses all year long.

It is apparent that private-sector employers have shifted at least some of the costs of health care to employees in the form of less comprehensive coverage to those with insurance. These relatively fortunate individuals, together with those who are less fortunate because they have no coverage at all, are at increased risk of being denied access to care they need for financial reasons.[15] When they do need publicly subsidized care, they add to the growing numbers of people who must depend on county programs for their health care. All these uninsured indigent patients must be served with far fewer financial resources today than were available even a very few years ago.

The results of this mounting problem are felt by all Californians. The uninsured experience it directly in the form of less access to needed medical care. All of us bear the burden of paying for the minimal care that is provided to this population. And essential emergency and trauma services are increasingly being denied to all people in many communities because of the burden posed by treatment provided to the uninsured. The problem of the uninsured already has reached crisis proportions. It requires the immediate attention of public policymakers.

Indigent Services Programs (MIA) and it gave the counties $240.0 million as the state's share of the County Health Services Program (AB 8) for inpatient and outpatient care while the counties spent $194.8 million in their own funds (net county costs) on the AB 8 inpatient-outpatient care program, for a total of $911.1 million. The total amount spent divided by the number of uninsured persons below 150% of poverty provides the per capita amount of $439. Data on total state and county spending on these programs for fiscal year 1983-84 provided by the County Health Services Branch, California Department of Health Services.

[13] In 1986-87, the state spent $542.2 million in the MIA program, gave the counties $279.0 million as the state's share of the AB 8 inpatient-outpatient costs, and the counties spent $290.9 million in net county costs on inpatient-outpatient care, for a total of $1,112.1 million. Data for fiscal year 1986-87 provided by the County Health Services Branch, California Department of Health Services, which validated their comparability to fiscal year 1983-84 data.

[14] The medical care component of the U.S. Consumer Price Index rose 21.1% between 1983 and 1986. We used the medical care component of the CPI because it is more appropriate to the health services that county indigent medical care programs must provide or pay for than would be the general CPI.

[15] R.A. Hayward, M.F. Shapiro, H.E. Freeman, and C.R. Corey, "Inequities in Health Services Among Insured Americans: Do Working-Age Adults Have Less Access to Medical Care than the Elderly?" *New England Journal of Medicine*, 1988, *318*:1507-1512.

Appendix A. Methods

The data base

We have examined changes in health insurance coverage of the California population between 1979 and 1986, using data from the Current Population Surveys (CPS) conducted by the U.S. Census Bureau in March of each year (the surveys ask about health insurance coverage during the previous calendar year). The March CPS provides information about work experience, income, family structure, migration, and other characteristics, including health insurance coverage. Data for those who were uninsured were not available for 1980 and 1981 (i.e., from the 1981 and 1982 surveys), but data on workers who received health insurance as a fringe benefit were available for those years. The data for each year are shown in Tables 1-3 in Appendix C.

The CPS sample is a national probability sample designed so that information appropriately weighted can be generalized to the U.S. population and to populations of large states such as California. Respondents to the CPS were interviewed by trained Census employees.

The health insurance coverage questions ask whether each person in a household was covered by a group health insurance plan (including prepaid group practices) obtained through employment (including plans requiring full, partial, or no employer contributions), individually purchased coverage, CHAMPUS or military medical services, Medicare, or Medicaid (called "Medi-Cal" in California). Persons covered by any of these sources *at any time during the preceding year* are counted as insured.

The remaining population -- those with no third-party coverage during the entire year -- are considered uninsured. Because people with coverage for even a brief period during the year are counted among the insured, *the CPS provides a conservative estimate of the uninsured population*.[16] Thus, the findings of this study do not deal with the extent of partial-year coverage. This is an example of the lack of more-detailed questions on health insurance coverage, which is a limitation of the CPS. It is thus important for the reader to remember that the findings based on this study represent only a portion of the uninsured population, which also includes some number of persons who are uninsured during part of the year. Futhermore, the CPS may undercount some of the very groups that are most likely to be uninsured, groups such as undocumented aliens and the homeless.

Finally, the CPS yields fairly reliable estimates of insurance coverage for large groupings within the state because the sample size in California is very large. (The CPS obtains data on more than 13,000 persons in the state.) Analyses of subgroups are less reliable because their smaller sample sizes are subject to more error. Rather than presenting standard errors for all estimated percentages in the report, we decided to present some for representative groups included within our analysis. These figures are approximations of the standard errors; they are derived from generalized standard error tables provided by the U.S. Census Bureau for estimated percentages.[17] Standard errors of estimated percentages for the California nonelderly population include: all persons under 65 years of age, 0.4%; children (0-17 years), 0.5%; adults (18-64 years), 0.4%; non-Latino white children, 1.0%; Latino children, 1.4%; black children, 2.5%; Asian and other children, 2.8%; non-Latino white adults, 0.4%; Latino adults, 1.3%; black adults, 1.6%; Asian and other adults, 1.9%; full-time, full-year employees, 0.5%; full-time, part-year employees, 1.2%; and part-time employees, 1.2%. Standard errors for smaller subgroups would, of course, be larger.

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[16] The CPS interview questions themselves strongly support this interpretation. However, some analysts argue that CPS really measures lack of insurance coverage at the point in time at which the survey is conducted, not the entire preceding year, because the CPS estimates of the uninsured are closer to the "point in time" estimates of some other major national surveys that investigate health insurance coverage than they are to the "all year" uninsured estimates from those surveys. For a thorough discussion of these issues, see K. Swartz, "How Different Are Four Surveys' Estimates of the Number of Americans Without Health Insurance?" Washington, D.C.: The Urban Institute, December 1984.

[17] *The Current Population Survey: Design and Methodology*, Technical Paper No. 40, Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, January 1978.

The trend analysis

We used unweighted, least-squares regression analysis to describe in a simple way the *average* changes in health insurance coverage between 1979 and 1986 -- that is, as a way to summarize the trend in the same way for various populations. The regression analyses fit the data during this eight-year period to a linear model in order to estimate the average trends. The results of these regression analyses are shown in the graphs as solid lines. The intercept, slope, standard error, p-value, and R^2 for each regression analysis are presented in Appendix B.

The reader should note that a linear model might *not* accurately reflect the changes that occurred in this period. Indeed, for certain subpopulations there were fluctuations from year to year that were not linear or even monotonic (i.e., either rising or falling). If the linear model does not fit the data adequately, the average trend estimated from the model is not very accurate or interpretable. In such cases, another (nonlinear) model may better fit the data and may more accurately represent changes that have occurred. We decided, however, not to fit more complicated models to the data because of the small number of observations (i.e., six years).

Appendix B. Regression Analysis Estimates of Trends

Figure	Group	Intercept	Slope	Standard Error of Slope	p-value	R^2
1	Number	-1.54e+07	239536.2	29721.8	.001	.94
2	Actual & Hypothetical	NA	NA	NA	NA	NA
3	Change in Percent	-25.7	.54	.12	.009	.85
Age Groups						
4	0-5 years	5.0	.18	.21	.44	.15
5	6-17 years	-24.1	.54	.24	.09	.55
6	18-29 years	-66.7	1.12	.07	.00	.98
7	30-44 years	-15.4	.37	.20	.14	.46
8	45-54 years	-30.8	.55	.13	.01	.81
9	55-64 years	.98	.19	.29	.56	.09
Family Incomes Relative to Poverty: Children						
10	<100% Poverty	31.8	.00	.36	.00	.00
11	100-149%	-111.6	1.74	.53	.03	.73
12	150-299%	18.6	.03	.24	.89	.01
13	300%+	-12.6	.27	.21	.27	.29
Family Incomes Relative to Poverty: Adults						
14	<100% Poverty	-41.7	1.02	.42	.07	.60
15	100-149%	-101.3	1.65	.43	.02	.78
16	150-299%	-38.5	.75	.30	.06	.62
17	300%+	-9.5	.24	.07	.02	.76

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Appendix B. Regression Analysis Estimates of Trends (Continued)

Figure	Group	Intercept	Slope	Standard Error of Slope	p-value	R^2
Ethnicity: Children						
18	Non-Latino White	35.8	-.24	.37	.56	.09
19	Black	-68.9	1.08	.64	.17	.41
20	Latino	-81.4	1.33	.45	.04	.69
21	Asian/Other	56.2	-.44	.64	.53	.11
Ethnicity: Adults						
22	Non-Latino White	7.66	.10	.17	.58	.08
23	Black	-18.2	.45	.56	.47	.14
24	Latino	-132.7	1.97	.30	.001	.91
25	Asian/Other	11.8	.10	.21	.67	.05
Labor Force Participation						
26	Not in Labor Force	-8.0	.41	.37	.33	.23
27	All Workers	-38.6	.66	.12	.005	.89
28	Bar Graphs	NA	NA	NA	NA	NA
29	Self-Employed Workers	-66.2	1.22	.31	.02	.79
30	Private Employees	-49.2	.81	.10	.001	.94
31	Government Employees	24.7	-.21	.18	.31	.25
Full- & Part-Time Employees						
32	Full Time-Full Year	-36.9	.56	.20	.05	.66
33	Full Time-Part Year	-64.5	1.07	.21	.01	.87
34	Part Time	-65.7	1.08	.43	.06	.62
35	Bar Graphs	NA	NA	NA	NA	NA

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Appendix B. Regression Analysis Estimates of Trends (Continued)

Figure	Group	Intercept	Slope	Standard Error of Slope	p-value	R^2
Employees With Fringe Benefit						
36	Full Time-Full Year	148.3	-.83	.32	.06	.64
37	Full Time-Part Year	164.4	-1.38	.27	.01	.87
38	Part Time	49.1	-.34	.38	.42	.17
Employee Fringe Benefits in Selected Industries						
39	Durable Goods Manufacturing					
	Full Time-Full Year	85.96	.02	.31	.94	.001
	Full Time-Part Year	74.54	-.10	.61	.88	.004
	Part Time	-25.29	.73	1.65	.68	.03
40	Nondurable Goods Manufacturing					
	Full Time-Full Year	224.12	-1.75	.45	.01	.72
	Full Time-Part Year	134.90	-1.00	.79	.25	.21
	Part Time	104.61	-.98	.71	.22	.24
41	Construction					
	Full Time-Full Year	167.37	-1.14	.72	.17	.29
	Full Time-Part Year	325.96	-3.35	.77	.005	.76
	Part Time	256.69	-2.82	.61	.004	.78
42	Retail					
	Full Time-Full Year	183.28	-1.42	.37	.01	.71
	Full Time-Part Year	95.32	-.70	.49	.20	.26
	Part Time	29.53	-.13	.39	.74	.02
43	Service Sector (business, repair & personal service)					
	Full Time-Full Year	78.04	-.17	.7	.82	.01
	Full Time-Part Year	57.77	-.32	.36	.41	.12
	Part Time	47.73	-.45	.29	.17	.29
44	Agricultural, Forestry, & Fishing					
	Full Time-Full Year	268.66	-2.57	.93	.034	.56
	Full Time-Part Year	251.39	-2.75	1.07	.042	.53
	Part Time	120.08	-1.30	.9	.2	.26

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Appendix B. Regression Analysis Estimates of Trends (Continued)

Figure	Group	Intercept	Slope	Standard Error of Slope	p-value	R^2
Employee Fringe Benefits By Ethnicity						
45	Non-Latino White					
	Full Time-Full Year	90.4	-.10	.29	.73	.02
	Full Time-Part Year	82.8	-.35	.23	.18	.28
	Part Time	32.3	-.13	.38	.75	.02
46	Black					
	Full Time-Full Year	44.4	.43	.58	.49	.08
	Full Time-Part Year	167.2	-1.43	.97	.19	.27
	Part Time	91.7	-.87	.88	.36	.14
47	Latino					
	Full Time-Full Year	193.1	-1.5	.48	.02	.62
	Full Time-Part Year	207.1	-2.02	.36	.001	.84
	Part Time	68.2	-.58	.42	.217	.24
48	Asian/Other					
	Full Time-Full Year	133.2	-.67	.45	.19	.27
	Full Time-Part Year	99.8	-.62	1.08	.59	.05
	Part Time	93.1	-.87	.44	.09	.40

Note: "NA" indicates that regression analyses were not applicable for a particular figure.

Appendix C. Tables

Table 1. Percentage of Nonelderly Persons Who Were Uninsured by Age, Family Income, and Ethnicity by Year, California, 1979-1986

	1979	1982	1983	1984	1985	1986
Age						
Total Nonelderly (Less than 65 years)	17.4%	20.0%	19.3%	19.9%	21.6%	21.1%
Children (Less than 18 years)	18.6	22.1	19.9	20.3	22.5	21.6
<6	19.4	21.2	18.7	19.1	21.2	21.0
6-17	18.1	22.6	20.6	20.9	23.2	21.9
Nonelderly Adults (18-64 years)	16.9	19.2	19.1	19.7	21.3	20.9
18-29	22.4	24.9	26.1	27.5	29.0	30.1
30-44	13.7	16.0	14.2	15.6	17.5	15.7
45-54	12.7	14.6	14.9	15.6	17.3	15.8
55-64	14.9	17.9	18.0	14.7	16.0	17.7
Family Income: Children						
Below Poverty	32.0	34.0	30.1	29.4	32.9	32.9
100%-149% of Poverty	27.2	30.8	27.6	36.0	35.4	39.7
150%-299% of Poverty	20.5	23.3	20.9	20.7	22.5	20.7
300%+ of Poverty	8.8	9.6	8.3	8.6	11.5	10.3
Family Income: Nonelderly Adults						
Below Poverty	40.6	39.0	44.8	43.0	47.7	46.1
100%-149% of Poverty	28.6	34.9	31.9	39.0	40.4	38.6
150%-299% of Poverty	21.8	23.1	21.5	23.2	26.7	26.9
300%+ of Poverty	9.4	9.6	9.5	10.1	10.7	11.0

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Table 1. Percentage of Nonelderly Persons Who Were Uninsured by Age, Family Income, and Ethnicity by Year, California, 1979-1986 (Continued)

	1979	1982	1983	1984	1985	1986
Ethnicity: Children						
Non-Latino White	16.4	19.5	13.7	16.7	16.2	15.0
Black	18.8	18.4	18.2	19.9	20.2	29.1
Latino	23.2	28.8	31.8	26.6	32.8	33.3
Asian/ Other	20.2	20.5	18.4	21.2	23.0	13.3
Ethnicity: Nonelderly Adults						
Non-Latino White	14.7	16.9	16.1	16.2	16.6	15.1
Black	19.2	18.2	18.4	20.2	16.4	25.2
Latino	24.4	27.3	30.7	31.6	37.1	37.1
Asian/ Other	18.9	21.9	19.0	20.1	20.4	19.9

Table 2. Percentage of Adults 16-64 Years of Age Who Were Uninsured by Labor Force Participation by Year, California, 1979-1986

	1979	1982	1983	1984	1985	1986
Not in Labor Force						
Total	24.0	28.2	26.3	24.4	29.1	26.7
Unemployed	41.2	44.8	40.6	39.1	48.5	43.4
Retired	19.4	21.3	19.7	18.2	25.9	19.6
Ill	17.3	17.6	19.4	18.3	21.1	19.5
Homemaker	20.1	25.0	22.5	19.5	23.9	21.8
Student	28.7	33.6	29.6	29.2	37.2	33.5
Other	64.1	55.9	61.7	60.1	57.7	62.4
Workers by Sector						
Government Employee	8.1	7.9	7.3	6.2	8.5	6.0
Private Employee	15.1	16.5	17.2	18.9	20.0	20.3
Self-Employed Worker	30.4	32.6	33.9	38.9	38.1	37.3
Employees by Full- and Part-Time Employment						
Full Time-Full Year	8.6	7.7	8.9	10.1	11.1	12.3
Full Time-Part Year	21.0	22.4	23.1	25.5	28.0	27.5
Part Time	18.5	24.5	24.9	25.0	29.2	24.3

Table 3. Percentage of Employees 16-64 Years of Age With Health Insurance as Fringe Benefit by Full- and Part-Time Employment and Ethnicity by Year, California, 1979-1986

	1979	1980	1981	1982	1983	1984	1985	1986
Full- and Part-Time Employment								
Full Time-Full Year	77.8	79.9	81.5	82.9	79.5	78.2	78.2	75.2
Full Time-Part Year	51.0	51.1	52.7	53.1	50.9	46.8	47.1	44.9
Part Time	20.6	21.0	23.5	25.0	20.7	18.3	19.3	20.8
Ethnicity								
Non-Latino White	61.2	62.6	64.2	64.7	62.9	60.2	63.5	62.8
Black	59.3	60.7	64.3	62.3	60.8	58.2	65.6	58.1
Latino	53.5	55.2	55.0	54.9	51.3	50.8	47.7	46.0
Asian/Other	60.8	60.3	63.9	62.3	62.7	59.5	60.0	57.0

Chairman STARK. Thank you both.

I wish Professor Brown, that we could find you a few more votes for a national health insurance program, but I have a hunch that that was laid to rest back in the 1960's. While I agree with you, I guess we are just going to have to do it a piece at a time. That seems less evident to me and socially less desirable, but it is a practicality. I think there are a lot of people who fight having it done.

I think they recognize that eventually we will get there, but we are going to have to do it in a far less efficient way, putting little groups here and there into a program and hopefully, by the end of the century, we will have a fair way to pay for medical care for everyone when it is needed and not have to wait until they are in a sad state being dragged into an emergency room in a coma before they get care.

I agree that preventive medicine is the best alternative, but we just don't have the luxury of doing it.

Dr. Chollet, while you suggested to me that the Employee Benefit Research Institute does not take any policy positions, maybe you do. You massaged these numbers and were playing with them. I want to ask you as an individual after crunching these numbers with all the care that you have, would you offer any advice to the committee on which segment of these 37 million people we ought to work on first?

I suspect you would say the children, but then how do we get there? I can't believe you spent so much time doing this research and you didn't have any time for some gratuitous advice.

Ms. CHOLLET. I have gained some intuition about what might be the fastest way to approach this population and get some results. There is no simple unilateral type of thing to do. That is clear. I think the number of individuals in the population who have no insurance who are attached to a worker is a compelling statistic.

Since employers provide upwards of 85 percent of all private health insurance to the population, I think it makes sense to look at that system as a primary resource for health insurance and ask what can be done with that system to improve it and make it more equitable and tolerable for employers.

Chairman STARK. Would it be a lot cheaper to pay the marginal addition, is that it or is there a reasonable assumption? If you swallowed the cost of including dependents, in other words, there are a lot of workers who have personal insurance, but do not have dependent coverage.

One presumes if they paid for participating, the children would have coverage. Is that any cheaper because the system is in place or what?

Ms. CHOLLET. Dependents' coverage is very expensive. It can easily double the cost of insuring a worker. That is one reason employers are asking employees to pay part of the costs. Any kind of expansion like that is not going to be an easy thing.

The small employers say the reason they don't offer the insurance to their workers is because of the cost of the plan. My reading of the data is that the cost of the plan is relative to the value of the worker. No employer of any size is particularly likely to cover some types of workers. These are the workers whom we see uninsured.

Typically low-wage workers. Neither large nor small firms are covering them. The small firms simply have more of them.

Chairman **Stark**. I suspect you see a lot of large corporations contracting out maintenance or janitorial work in order to save the benefit program themselves.

Ms. **Chollet**. It would be very possible. I personally would like to see us pay more attention to the notion of reducing the cost of health insurance and making relatively incremental changes in a voluntary system of health insurance before we go down the path of mandatory health insurance.

I would not say it would be an immediate or universal success. Even a mandated system will fray at the edges if the costs rise too much. There are many aspects of our current health insurance system that make it extremely expensive for small employers or inaccessible to small employers.

I think we ought to look carefully at our system of medical underwriting to which small employers are subject and large groups are not, and at how insurance is offered to small groups. These matters deserve careful attention.

Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. I am very interested in this question of coverage that you talked about before. I am trying to understand why it is not provided. Broadly speaking, does the proportion of uncovered people relate to the general wage level in a community, lower wage levels accompanied by lower coverage or is it because of higher health costs, which would make it more expensive?

Do you have a handle on that?

Ms. **Chollet**. I think it is both. I think the chief characteristics of States with low rates of coverage are low employer coverage, probably relating to low wages and relatively high costs of health care, and low coverage by Medicaid. The two always produce low rates of coverage in the area.

I think the wage levels in the area vary more substantially than the cost of health care. That appears to be relatively rigid. There are a variety of reasons why health care does not vary as much as wages. That cost rigidity puts some employees in jeopardy of not getting health care because the cost is so high relative to their wages.

Mr. **Gradison**. I wonder as we watch the number of uninsured rise the extent to which newer businesses, seeing the inflation of health care costs, are more cautious than comparable businesses 10 or 20 years ago about agreeing to a commitment which is sort of open ended and it is pretty much beyond their control as far as the businesses themselves are concerned.

It is wide speculation on my part. I have been interested to watch what has happened so far among those few employers offering long-term care. These employers are basically a group plan but they are not putting anything into it other than the administrative costs.

To me that may be a way of saying, we want to be helpful and responsive but we are not going to let what happened to us in acute care happen to us by signing on to an open-ended benefit for long-term care.

Ms. **Chollet**. There is a parallel to that for the uninsured population that is not retired. I think one of the problems confronting small employers is increasing legal inflexibility with respect to the health insurance benefits they provide to their workers.

I think, for example, that the benefits costs and the administrative expense imposed by COBRA and the administrative burden of the section 89 rules are significant. Continuation especially can add inflexibility. When employees are taken off the payroll they are not taken off the books.

I think employer reluctance to entertain the notion of mandated insurance benefits in part relates to recent experience with mandates from the Federal Government.

Mr. **Gradison**. I saw a nasty, ugly case of this in my own district. It was a small employer manufacturing a single product which is sold in very price competitive markets found that the average cost of health care for each of his employees was $3,000 a year, which is not that unusual. That is what it was. He cannot afford it. He tried to negotiate a contract to scale it down. There was a strike and he replaced all the workers.

It was very unfortunate. In that instance, the employer felt the survival of the whole enterprise was at stake because of that cost.

Thank you, very much.

Mr. **Brown**. May I add a comment to the issue of the possibilities of reducing the cost of private insurance?

We have actually seen that employers have taken a number of steps, and one of the methods they have used is to shift a considerable portion of the financial burden of health care off their own shoulders on to that of their employees, in part to make the employees more cognizant of the cost. But what it does is to increase the financial burden for medical care to the working population, something that many of them feel that they simply cannot afford.

I know that in California the public has become very concerned about this issue. And public opinion polls have consistently demonstrated strong public concern and public support for public programs, publicly run programs to deal with these problems and also consistently expressed willingness to even pay higher taxes in order to assure adequate access to medical care for the elderly and poor.

I don't think the depths of that public support have been adequately studied, but I think it is there.

Mr. **Gradison**. We are testing that with the Stark-Gradison Bill, Mr. Chairman, and right now we are getting beat up pretty good by the people paying for it; we are market testing.

Thank you very much.

Chairman **Stark**. Just reviewing the California Commission on Aging who held hearings on our catastrophic bill, they assume a very small percentage of people enjoy benefits. But the hope is that what they buy will no longer be necessary and may not be quite as much as they thought they had, but it is a tough sell. It is not one of the most popular pieces of legislation.

I Thank both of you.

Our next witness is a panel.

We welcome you both back to the committee.

Your testimony will be put into the record in its entirety. Dr. Schramm, proceed in any manner you choose.

STATEMENT OF CARL J. SCHRAMM, PH.D., J.D., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Schramm. Thank you.

I am grateful to have the opportunity to come before you this morning and talk about the commercial insurance industry's approach to the problem of 35 to 38 million people who are without a financial mechanism to pay for health care and as a result are in many instances without access to the wonders of American medicine.

The Health Insurance Association of America has been at work on this problem for over 2 years, and I am pleased to report we believe we have a program that would comprehensively deal with all 35 to 38 million people without care.

One fundamental observation that has been made earlier this morning is that the complexity of the uncovered population requires us to think about multiple approaches. As you have heard, one-third of the uncovered are below the Federal poverty level, one third are the near poor, between 100 and 200 percent of the poverty level, and one third of those without health insurance are over 200 percent of the poverty level.

Eleven percent of the uninsured are the self-employed and their families, 13 percent are half-time employees and their families and 51 percent are full time employees or dependents of full-time workers. All of these factors make any single solution difficult.

The special needs of the various subpopulations within the 35 to 38 million require a multi-pronged approach. We believe we should take four steps jointly with government to solve this problem.

The first is that the public sector must be responsible for the poor. Medicaid should be expanded to all those below the Federal poverty line regardless of family structure or employment status.

Specifically, we would like to see the following changes made in the Medicaid eligibility standards.

We should eliminate categorical restrictions on eligibility for Medicaid and Medicaid spend-down.

We should allow states to uncouple the income eligibility standards for welfare payments from eligibility for Medicaid.

We should eliminate eligibility restrictions, such as the limit on hours worked, for those individuals and families who may be employed but still remain below the eligibility income standard.

And finally, we should require all States to have a medically needy program and to allow low income individuals to buy into Medicaid, preferably though an income related premium.

A second feature of our approach suggests that insurers should be allowed to offer more affordable coverage including prototype plans. ERISA preemption of State mandated benefits should be extended to insured employee plans as well as to self-insured plans so insurers can design less expensive benefit packages for small businesses.

HIAA will support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarial equivalent in value and include basic in-patient and out-patient physician, hospital and diagnostic services.

Additional services, such as dental and mental health, would be offered in some prototypes in exchange for higher copayments, and in all prototype plans managed care features would be encouraged and certainly permitted.

The third point of our proposal suggests coverage must be made available to all Americans. This is true even for those whom insurers might normally decline due to existing high cost medical or occupational conditions.

There are two components to consider here, uninsurable individuals and uninsurable employer groups. We continue to seek Federal legislation encouraging all States to enact a qualified State pool for medically uninsurable individuals. Such pools have been already enacted in 15 States.

Early in this Congress we sent every Member of this committee suggested legislation which would guarantee such a pool in every State while still meeting objections raised by employer groups, and we look forward to working with you to make such a proposal a reality.

To insure access to group coverage for all employees, we are proposing a non-profit organization be established to reinsure uninsurable employer groups. Employers would access the reinsurance organization, indirectly via insurers, or directly if unable to purchase coverage through an insurer.

Losses incurred by the reinsurance corporation could be financed entirely by the private sector if shared equitably among competitors in the small group market and all large health plans whether insured or self-insured.

Finally, we believe small business must be given a greater incentive to provide coverage for their employees. Self-employed individuals should get 100 percent deductions for their health insurance protection as long as they provide equal coverage to their employees.

In that regard we want to commend you for the introduction of H.R. 5169 which would provide a 100 percent income tax deduction for the self-employed, and for those portions of H.R. 4951 which do, in fact, coincide with our suggestions.

However, we believe it unwise and unnecessary to propose a system of employer mandated insurance until proposals which focus on assisting small employers have actually been tried and found wanting.

It is our belief the four point plan that I have outlined presents a blueprint for a truly comprehensive approach to the problem of all uninsured citizens.

The plan stresses sharing of responsibility between government and the private sector. We offer no magic bullet and no free lunch.

I would conclude, Mr. Chairman, by just pointing out, as you have undoubtedly seen, the editorial in this morning's Washington Post about the Dukakis plan. I think the Post is to be commended because it points to a reality so often overlooked as we talk about this.

In the last paragraph I quote, "Any improvement in health insurance is going to have to be accompanied by cost controls."

Speaking as a former professor who studied this for 14 years, as a former member and Chairman of the Maryland Health Service Cost Review Commission, the agency that regulates hospitals in the State, it seems to me that before we make any progress on the issue of coverage, we have to concurrently discuss the question of what we do about the extraordinary cost inflation pointed up only two days ago by the release of BLS indications that, once again this month, to no one's surprise, the medical care component has outpaced all other factors.

The implications of that are clear. A previous witness referred to enacting a plan which would continue to ravel at the edges before it even took effect.

The Kennedy-Waxman plan, speaking directly to the uninsured working population, would within months produce still larger numbers uninsured as employers worked around whatever we imposed to avoid the incredible cost burdens.

I would conclude by saying once again there is plenty of money in this system, it is a question of redistribution. Ten years ago we had more people covered than we have now, and we spent less.

Hospitals admit fewer people for shorter lengths of stay, but their aggregate cost in real terms is higher than ever before. At the same time we have supported a enormous growth in the number of physicians, physicians visits and the number of out of hospital facilities in which medicine is delivered.

I believe the real problem we have looked at for the last few years, the objective of all of this legislation, is a redistribution problem. And we are ready to work on that with you.

Thank you.

[The statement of Mr. Schramm follows:]

STATEMENT OF CARL J. SCHRAMM, PRESIDENT HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Carl J. Schramm, President of the Health Insurance Association of America. HIAA is a trade association of 360 commercial insurance carriers who provide approximately 40 percent of the health insurance services in the United States. Approximately 10 percent of our membership's business comes from individuals, 40 percent from employers with fewer than 100 employees, and 50 percent from employers with more than 100 employees. The combined efforts of HIAA's members, the Blues plans and HMOs have succeeded in protecting 180 million Americans. However, we recognize that this is not enough.

Mr. Chairman, our member companies are greatly concerned about those 35 million Americans who do not enjoy the protection of health insurance. Over the last two years, our membership has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. On behalf of HIAA, I am pleased to report a commitment among our companies to work with government in implementing effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured, and the very nature of this group requires a combination of private and public solutions.

One third of the uninsured are poor (with family income below 100% of the federal poverty level); one third are near poor (between 100% and 200% of the poverty level); and one third are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make any single solution difficult. As such we see the need to address the special needs of the various subpopulations within the 35 million uninsured with a simultaneous multi-pronged approach. We propose a specific four-point plan which, taken as a whole, provides a comprehensive blueprint to cover the uninsured:

1) The public sector must be responsible for the poor. Accordingly, HIAA proposes the expansion of Medicaid to all those below the federal poverty level, regardless of family structure or employment status.

Ultimately, we would like to see the following changes made in the Medicaid eligibility standards:

- Eliminate categorical restrictions on eligibility for Medicaid and Medicaid spend-down so that Medicaid is made available to anyone below the federal poverty level;

- o Allow states to uncouple the income eligibility standards for welfare payments from eligibility for Medicaid;

- o Eliminate eligibility restrictions (such as the limit on hours worked) for those individuals and families who may be employed, but still remain below the eligibility income standard;

- o Provide opportunities for other low income individuals to participate in Medicaid by requiring allstates to have a medically needy program and by allowing low income individuals to buy into Medicaid, preferably through an income-related premium.

2) Insurers should be allowed to offer more affordable coverage, including prototype plans. ERISA preemption of state mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small businesses.

HIAA will support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarially equivalent in value and include basic inpatient and outpatient physician, hospital and diagnostic services. Additional services, such as dental and mental health, would be offered in some of the prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted.

3) Coverage must be made available to all Americans. This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable individuals and uninsurable employer groups.

HIAA seeks Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals. Such pools have already been enacted in 15 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity. In the absence of action by a state, the Secretary of the Department of Health and Human Services (HHS) should establish a qualified pool in that state, in which case losses, if any, would be paid from federal health funds the Secretary would otherwise spend in the state.

To ensure access to group coverage for all employees, a nonprofit organization should be established to reinsure uninsurable employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among competitors in the small group market and all larger health plans whether insured or self-insured.

4) Small businesses must be given a greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction for their health insurance protection, as long as they provide equal coverage to their employees.

It is our belief that this four-point plan provides a blueprint for a truly comprehensive approach to the problem of uninsured citizens. The plan stresses the sharing of responsibility between government and the private sector. It calls on the private sector to provide for new private products and practices and government to reinforce its 1965 commitment to poor citizens through the Medicaid program.

We believe it unwise and unnecessary to propose a system of employer mandated insurance until proposals which focus on assisting small employers have actually been tried and found wanting. In that regard we do want to recognize and commend the chairman for the introduction of H.R. 5169, which would provide a 100 percent deduction for the self-employed, and for those portions of H.R. 4951 which do in fact coincide with our suggestions.

In closing, I would recall that the private insurance system is built on the principle of risk selection. It is a highly competitive industry, composed of over 600 companies, committed to providing insurance to ever larger numbers of Americans. Using high risk pools and reinsurance we could underwrite anyone regardless of their health status. But we cannot insure anyone regardless of their ability to pay.

Mandating coverage will not change this fundamental reality, nor make coverage affordable. Health insurance is expensive because health care is expensive. There are no magic bullets or free lunches. But we can work together to develop and implement effective solutions.

Thank you.

Chairman **Stark**. Thank you very much.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. **Lehnhard**. Thank you for the opportunity to testify. Blue Cross and Blue Shield Association also believes the problem of the uninsured should be addressed through a partnership of Federal, State and private sector initiatives, and we also have a four-part program.

First, we recommend the Government allow unincorporated businesses to deduct their full expense of offering health benefits, and we are very pleased to see H.R. 4951 would make this change.

Secondly, we also think that ERISA should be modified to take care of the problems of State mandated benefits and again we are pleased that your bill makes this much needed change.

Third, we suggest a three part Medicaid strategy for the working low income and the strategy is outlined in our testimony. Essentially the strategy would establish minimal eligibility criteria.

And finally, we urge the Congress to give States the flexibility to include employers who provide benefits and risk pools as well as employers who insure their benefits and certainly your bill would address this problem, although indirectly.

In commenting more specifically on H.R. 4951, I would note our concern about a mandate or a tax penalty that has essentially the same consequence as a mandate. Our concern is that it would force the purchase of health insurance regardless of cost on the employer and many workers who can least afford it.

H.R. 5941 does partially address this concern with respect to the employee by providing for a tax credit for low-income workers.

Secondly, we very strongly support the use of the statewide pool concept in the bill versus the regional approach used in other legislation. We are very concerned there are major structural and regulatory problems associated with the regional pool.

Third, we strongly support the approach we believe H.R. 4951 offers of allowing private carriers who meet the requirements of these State pools to serve as such an entity. We believe that Congress should encourage private insurers willing to meet the benefit rating and underwriting medical requirements of the State pool to be selected to serve as the statue use pool.

The premiums in these private pools will be much lower because of the very large proportion of healthy subscribers versus unhealthy subscribers.

I would like to comment on the minimum benefit package defined in the bill. On the one hand, I think reference to a model benefit package may alleviate some of the concerns employers have of constantly adding to the benefit package and you have to pay for whatever you add as you well know.

On the other hand, we question whether medicare is the right package. When you look at the age of income statistics of the uninsured it suggests a really key question that hasn't been addressed—affordability versus comprehensiveness. I think every one has focused so far on the need of comprehensive coverage.

We are going to be taking a very close look at the question, looking at what is causing the current hospital bad debt, what the low wage workers need and try and take a fresh look at striking a balance between affordability and comprehensiveness.

Those are the key points in our testimony, and I will stop there.

[The statement of Ms. Lehnhard follows:]

STATEMENT OF MARY NELL LEHNHARD
VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and Members of the Committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 77 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 80 million Americans.

Since its inception in the 1930's, the Blue Cross and Blue Shield organization has been committed to developing and improving the nation's pluralistic health financing and delivery system in partnership with consumers, employers, unions, government, and health care providers. That commitment continues today as we address what is perhaps the most complex health financing issue -- the needs of the nation's remaining uninsured.

We welcome the opportunity to address the committee on this important matter. We are concerned, as you are, about the trend of the past decade -- a rise in the uninsured population from 25 million to more than 37 million people. Down this road lies even more financial hardship, less access to needed medical care and the increasing number of health problems that result when people avoid needed care because they lack the ability to pay for it. It appears certain that increasing numbers of our citizens will face these problems unless the public and private sector work together to find appropriate solutions.

This morning my testimony will focus on three key points:

- First, we believe that the current public/private system has served the nation well in extending health benefits, but gaps remain;

- Second, we believe that the needs of the 37 million uninsured should be addressed using a combination of approaches which rely on innovative private sector solutions while retaining public programs to protect those who cannot participate in private programs; and

- Third, we would like to comment on several aspects of H.R. 4951, the "Employee Health Benefit Improvement Act of 1988".

The Extent of Coverage and Remaining Gaps

The nation's current system of health care coverage provides protection for approximately 82 percent of Americans under age 65 through a combination of private and public sector programs. Congressional Budget Office (CBO) estimates of health insurance coverage illustrate how well this system is working. Of the population under age 65:

- 67 percent are covered through employment-based insurance;

- 7 percent are covered through other sources, such as individual insurance; and

- 8 percent are covered by Medicaid or Medicare.

While these numbers demonstrate the success of our current system, the estimates also reveal the lack of health benefits protection for nearly 18 percent of those under age 65, or 37 million individuals. The data also show that the number of uninsured has grown by about 25 percent since 1980 -- a period of general economic expansion.

The Blue Cross and Blue Shield Association believes that the solution to this long standing problem lies in a partnership of federal, state and private sector initiatives. While there is much the private sector can do to provide expanded health coverage, it is important to recognize at the outset that the private sector will not be able to address the health protection needs of all segments of this population.

Let me briefly describe what we believe the private sector can do and what the government could do.

Private Sector Initiatives

A significant portion of the employed uninsured work for small businesses; fewer than half of firms with under ten workers offer health insurance. The Blue Cross and Blue Shield organization has made a commitment to assure the availability of coverage to these small employers. Currently, approximately 98 percent of Blue Cross and Blue Shield Plans offer benefits to groups as small as five -- and nearly half will insure employer groups as small as two.

Blue Cross and Blue Shield Plans have a number programs underway or in development to meet specific needs of the uninsured. These programs include:

Children in Low Income Families. The Employee Benefits Research Institute (EBRI) estimates that one third of the uninsured are children under the age of 18. In recognition of this, many Blue Cross and Blue Shield Plans have developed innovative products especially designed for children who, for financial reasons, lack access to important preventive and primary care health services.

In 1985, Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield, in response to the number of unemployed and marginally employed people in the state, created the "Caring Program for Children."

The Caring Program offers primary health care coverage to children who are not eligible for Medicaid but whose parents cannot afford health insurance. Since its inception, nearly 10,000 children have received primary preventive and emergency health care service coverage at no cost to their families. Benefits include full coverage for: emergency outpatient medical care; minor surgery and diagnostic tests; outpatient surgery; emergency accident care; pediatric preventative health maintenance; and, unlimited medically necessary physician office visits and diagnostic tests.

Through contributions of $13 a month, foundations, businesses, unions, individuals, and civic and religious organizations are able to sponsor children regardless of their medical condition. Blue Cross of Western Pennsylvania matches every contribution, dollar for dollar, thus enrolling two children for every one sponsored by a public contribution. The Plan has further expressed their commitment to these children by subsidizing the administrative costs of the program so that nearly every dollar contributed goes directly towards providing health coverage to a needy child.

A number of other Blue Cross and Blue Shield Plans have developed similar programs within the past year including Plans in Missouri, Maryland, Alabama, North Carolina, North Dakota, and Central New York.

Delaware Temporary Service Coverage. Blue Cross and Blue Shield of Delaware developed "BlueMax" to address the health care protection needs of the increasing number of people who work on a temporary or part-time basis who otherwise would not have access to an employer-sponsored health plan. To be eligible for enrollment in the program, an employee must work at least 30 hours per week or 360 hours per quarter and have been with a temporary agency for 90 days.

Under BlueMax an employee can enroll in one of two traditional health plans or one of two HMOs. Premiums, copayments and deductibles vary with the coverage package chosen. Benefits typically include inpatient and outpatient hospital services, surgical-medical services, hospice care, home care, prescription drugs, and diagnostic and therapeutic benefits. Dental benefits also are available. Managed care features are incorporated into all offerings to curb unnecessary utilization without reducing the quality of benefits.

Temporary Coverage. Temporary coverage is another way to meet the needs of employed adults who might experience a lack of coverage due to circumstances such as a job change, layoff, strike, or other circumstances which might interrupt coverage. Several Blue Cross and Blue Shield Plans have developed short-term products for those who face these temporary periods without health coverage. For example, Blue Cross of Washington and Alaska offers short term protection against costly medical bills at rates as low as $30 a month. There is no deductible and the program will pay 80 percent of the first $5,000 of covered expenses up to a maximum of $250,000. Applicants are automatically enrolled when they mail in a completed form.

Coverage can be obtained for periods of 30, 60, 90, 120, or 180 days. Services include inpatient hospital care including intensive and coronary care; surgical care; outpatient hospital services; emergency room treatment; emergency ambulance service; and physician services. This product also includes benefits for necessary medical supplies, prosthetics, inpatient rehabilitative care and home health care.

The Unemployed and Marginally Employed. In recognition of the fact that nearly two-thirds of the uninsured population live in poverty or within 200 percent of the federal poverty level, initiatives are underway to develop products that are tailored to the needs of this population. For example, in a cooperative effort with the Kansas Medical Society, the Kansas Hospital Association and other health care providers, Blue Cross and Blue Shield of Kansas began a pilot program in January 1988 to provide health benefits for the state's unemployed and marginally employed. This program is designed to provide benefits to individuals and families who are low income and are not covered by group insurance plans or by state or federal health care programs. Applicants must: a) meet income eligibility limits of $8,000 per year for single persons or $15,000 for families; b) not be employed full time; and c) be under age 65.

Monthly premiums are based on subscriber age and begin as low as $17.35 (single) and $38.58 (family). Family coverage includes dependent children up to age 23. Area churches and philanthropic groups are being encouraged to contribute toward the cost of the premiums for needy individuals and families.

Covered benefits under this program include: inpatient and outpatient hospital services, medical and surgical services, emergency care, maternity and newborn care under a family contract, and care for nervous and mental conditions. Deductibles for a 12-month contract period are $1,000 for individual and $2,000 for families; however, health care providers who participate in the program assume responsibility for half of the deductible.

Non-Group Coverage. Blue Cross and Blue Shield of Tennessee has introduced "IMPACT", a comprehensive, non-group product line which incorporates cost-saving features commonly found in large group products.

IMPACT is available to self-employed individuals, employers with four or fewer employees, individuals without access to health care benefits under a group plan, and students.

IMPACT subscribers have their choice of three separate benefit plans. All three plans pay 80 percent of covered charges with caps on out-of-pocket expenses ranging from $1,000 to $5,000. Above this limit the plans pay 100 percent of covered services up to a lifetime maximum of $1 million. Benefits include hospice, home care and a special organ transplant coverage endorsement with additional benefits of $1 million. IMPACT also features an automatic payment service through bank checking or savings accounts.

Cost-saving features include pre-admission certification, pre-admission testing, concurrent care review, ambulatory surgery when possible, and voluntary second surgical opinions.

With a 10-percent discount for non-smokers, IMPACT offers premiums as low as $28.13 a month for individual subscribers under age 29. Deductible options of $200, $500, and $1,000 are available with maximum family deductibles of $600, $1,500 and $3,000 respectively.

While we are committed to activities that extend coverage to uninsured children and adults and will continue to seek ways to reach more of the uninsured, we recognize that the private sector cannot address the entire problem.

Blue Cross and Blue Shield Association Position

Blue Cross and Blue Shield Association believes that the long-standing problem of the uninsured should be addressed through a partnership of federal, state and private sector initiatives and recommends a four part program.

1) Increasing Incentives for Employers to Provide Coverage: With the assistance of the federal government the private sector could do even more to expand employment-based coverage. Certain segments of the small employer community -- the self-employed and unincorporated businesses -- need the same tax incentives to purchase coverage as are available to the rest of the employer community. These businesses -- many of which will be the target of our efforts to expand coverage -- currently can deduct only 25 percent of the cost of providing health benefits. This is in contrast to incorporated businesses which can deduct 100 percent of their health benefit expenses.

The Blue Cross and Blue Shield Association recommends equalizing the tax treatment of employers to provide a greater incentive for the self-employed and unincorporated businesses to offer health benefits. We are pleased to see that H.R. 4951 includes language which would make this much needed change.

2) Providing more affordable benefit plans: The private sector also could do more provided it had the flexibility to offer lower cost health benefit packages to small employers. In a recent survey of all Blue Cross and Blue Shield Plans, cost was cited as the overwhelming reason for small employers not offering coverage.

Unfortunately, while the smaller employer who may want to offer benefits appears to have the greatest need for more affordable benefit packages, insurers have the least ability to meet that need because of state mandated benefit laws. These mandates vary by state but can include benefits that add considerably to the cost of coverage. For example, one Blue Cross and Blue Shield Plan found that mandates were responsible for slightly over 20 percent of total claims costs.

The federal Employee Retirement Income Security Act (ERISA) allows self-funded employers, usually large employers, to tailor the benefits they offer by preempting these state mandated benefit laws. However, insured products -- the type the smaller groups generally purchase -- remain subject to those mandates.

The Blue Cross and Blue Shield Association recommends that the ERISA exemption be modified and extended to all benefit plans -- both insured and self-funded -- to allow insurers to develop the type of lower cost benefit package that could be more attractive and affordable to the smaller employer.

3) Expand Medicaid for the Low-Income: While the private sector -- coupled with federal government incentives -- can do much on its own, we believe that governmental efforts need to be targeted to the other high priority groups that are not likely to purchase private coverage. Nearly 45 percent of the uninsured -- more than 16 million individuals -- are employed, and over 12 million of these employed individuals have incomes below $10,000 a year. However, even those with incomes below the federal poverty level are ineligible for Medicaid benefits because of their employment status. Coverage remains limited in the work setting for many of low income employees because employers with a substantial number of low-wage workers face a sizable increase in their costs if they offer health benefits. Because lower income employees are often unable to command both adequate wages and health benefits, they frequently have to choose between employment and health benefits.

The Blue Cross and Blue Shield Association recommends a three-part Medicaid strategy to address this problem:

- Institute Mandatory Income Eligibility Levels. First, the federal government should set a mandatory minimum income eligibility level for states. In 1987, 22 states had income eligibility levels below 50 percent of the poverty line, with some states ranging as low as 15 percent. The Congress took a major step this year by phasing in required coverage of pregnant women and infants in families with income up to the federal poverty level. We recommend that policy be extended to require states to increase income eligibility levels for all individuals. If necessary because of the additional cost to states, the minimum eligibility level could be set at 60 percent of the federal poverty level and phased up to 100 percent over time.

- o Break the Welfare Link. Second, Medicaid eligibility should not be linked to the welfare categories of the aged, blind, disabled and members of families with dependent children. Anyone, including working individuals and their families, should be eligible for Medicaid if their income is below the income eligibility threshold.

- o Subsidize Benefits for the Low Income Working Uninsured. Finally, the federal government should provide for a sliding scale subsidy of health benefits expenses for the low income working uninsured with income above Medicaid eligibility levels but below 150 percent of the federal poverty level. This subsidy could be implemented by allowing a buy-in to a limited Medicaid package or by providing a limited Medicaid subsidy of the expenses of certain individual's health benefits at the workplace.

With these Medicaid eligibility changes, health insurance protection among low-income working individuals could improve substantially. In addition, these changes would help break the cycle of welfare dependency by providing individuals with the assurance that they would not risk losing their health coverage upon becoming employed.

4) Voluntary State pools for the high risk: We believe that the problems of individual people with medical conditions so severe they are considered uninsurable risks also need to be addressed through government-sponsored programs. Voluntary state risk pools are one means of making coverage available. These are state sponsored pools that offer coverage to those who, because they have a severe medical problem, cannot find private insurance.

Although we believe risk pools are an attractive means of increasing access to care, the need for such pools varies on a state-by-state basis. While not all insurers can accept people who are already severely ill and remain viable, many Blue Cross and Blue Shield Plans do accept all applicants, either during open enrollment period or on a continuing basis, regardless of the applicant's medical status. In states where Blue Cross and Blue Shield Plans offer open enrollment with no medical underwriting, and a community-rated premium there is no need for a high risk pool. The premiums in Blue Cross and Blue Shield Plans are much more affordable than even a subsidized high risk pool could offer because of the very large proportion of healthy enrollees compared to those who have high health care costs.

In states where pools are needed, we believe the federal government should provide states with the flexibility necessary to design and finance these pools on an equitable basis. Due to the effect of the preemption for state regulation of insurance provided under ERISA, the burden for subsidizing the current pools falls largely on mid-size and small employers.

More specifically, risk pools cover people who, by definition, have need of health care services, thus, the premiums are extremely expensive. If the premiums were based on the expected cost of providing coverage, very few individuals would be able to afford coverage. All of the 15 states that have enacted risk pool legislation have recognized this problem. The general solution has been to cap the total premium and include an additional source of financing.

We believe that state general revenues are the most appropriate mechanism for financing pool losses. This is the most broad-based and equitable mechanism for dealing with a problem which affects many different sectors of society. Unfortunately, only one state is financing its pool's losses through general revenues.

The rest of the states consider this an insurance problem and therefore assess insurers for the shortfall. Insurers incorporate the cost of the subsidy into the cost of providing coverage, thereby sharing it with employers who buy group and individual coverage. Because of the federal Employee Retirement Income Security Act (ERISA), which prohibits states from regulating self-funded employee benefit plans, only employers who buy coverage through insurers are affected by the additional cost. As a consequence, employers who self-fund their benefits avoid the costs of subsidizing the pools. Because it is primarily large employers who self-fund their employee benefits, the major part of the burden for subsidizing the pools falls on small and mid-size employers and individuals.

We believe that states need the flexibility to include employers who self-fund their benefits, as well as those who purchase insurance, in the financing of their risk pools.

Comments on H.R. 4951

Finally, I would like to make a few comments about H.R. 4951, the "Employee Health Benefit Improvement Act of 1988", introduced by Chairman Stark.

H.R. 4951 would impose a tax of $100 per day per employee on employers, excluding federal and state governments and churches, who do not provide qualified health plans to their employees. Qualified benefits would be similar to Medicare, plus maternity and child care benefits, with exclusions for pre-existing conditions prohibited. Employers would be required to contribute at least 80 percent of the premium, and could impose deductibles up to $1,500 per family and $1000 per individual but with no out-of-pocket expenses beyond those amounts. Employers would also be required to offer, and contribute to, continuation of coverage for 60 days after involuntary termination of an employee. States would be preempted from requiring health benefits richer than the federal minimum.

The bill provides for the establishment of qualified health care risk pools for all residents and employers in the state regardless of health status. Premiums for these pools could not exceed 150 percent of the average cost of a group standard risk policy in that state and losses would be paid by all employers in a state in proportion to each employer's wages paid in that state. However, if a state failed to establish a pool in any calendar year, employers would be assessed an excise tax and the HHS Secretary, through a competitive bidding process, would designate an entity to operate a pool.

The bill also increases the tax deduction for health insurance for the self-employed from 25 percent to 100 percent, and establishes a health insurance income tax credit of up to 50 percent of the employee contribution would be provided for low-income employees.

First, because three-quarters of the uninsured are employed or dependents of employed individuals many believe that the workplace is an appropriate avenue - via mandates, tax penalties, or tax incentives - to focus on when designing effective solutions. While we support efforts to strengthen our system of employer-provided health insurance, the Blue Cross and Blue Shield Association is concerned about the effect a mandate or, an overwhelming tax burden, could have on employees and on employers.

You have heard the varying economic analyses of the long-run wage and disemployment effects of a mandate. Our experience is much easier to summarize. We have worked very hard with employers of all types to try to encourage them to offer benefits to their employees. For the most part, when employers consistently reject us, and our competitors, and offer no benefits to their employees, it is because of one problem -- they cannot afford the cost. In a recent survey of our small group market, 87 percent of Blue Cross and Blue Shield Plans who responded cited cost as the most influential factor in an employer's determination of whether to provide health benefits coverage.

We are concerned about a mandate or a tax penalty that carries the same or greater cost as providing benefits -- it would force a purchase, regardless of cost, on the employer and worker who are least able to afford it. Faced with this situation employers may respond with lower pay, fewer hours for part-time workers or lay-offs. The Congressional Budget Office has already testified before House and Senate Committees on these possible effects.

Second, the Association strongly supports the use of the state-wide pool concept used in H.R. 4951 versus the regional approach used in other legislation.

One of the problems resulting from use of a community-rated regional pool is the resulting significant interstate subsidy. Under community-rated regional pools, some states would have per person rates that are higher than the average of the region and some states would have lower rates. This would result in employers and employees in lower cost states subsidizing employers and employees in higher cost states. For example, using Medicare data as a proxy for health costs in general, employers in Vermont could pay as much as 18% more for health benefits than they do currently because of the interstate subsidies of the pool.

Any adjustments to address this subsidy would be very difficult. Indicies could be developed to adjust the rates, but approval of this subsidy adjustment would be extremely difficult politically. Some would argue that the states with higher health care costs should be subsidized because the higher costs are justified, while others would argue that higher costs are due to inefficiency and should not be subsidized. The debate would be politicized and not unlike the current problems in resolving geographic adjustments needed in the Medicare DRG payment levels. For these reasons, the Association is pleased to see the use of statewide risk pools in H.R. 4951.

Third, we strongly support the approach we believe H.R. 4951 offers of allowing private carriers who meet the requirements of a qualified risk pool under the bill to serve as such an entity.

We believe the Congress should encourage private insurers who are willing to meet the benefit, rating, and underwriting requirements of a risk pool to provide such coverage in place of a state run risk pool. As mentioned before, a number of Blue Cross and Blue Shield Plans currently offer coverage on a community rated basis to anyone who applies, regardless of medical status. Premiums in those Blue Cross and Blue Shield Plans are much more affordable than even a heavily subsidized high risk pools could offer because of the very large proportion of enrollees who have low health care and compared to those who have high health care costs.

Finally, we would like to comment on the minimum benefit package defined in H.R. 4951. The benefits defined under this proposal must be at least equal to those benefits provided under Medicare. On the one hand, referencing a "model" benefit package may help alleviate the concern that employers and insurers have about a large number of benefits being added each year.

On the other hand, we question whether a program as comprehensive as Medicare is the most appropriate to use as a minimum benefit model. The Medicare package of benefits, quite appropriately, is designed to meet the needs of the elderly population, providing benefits such as unlimited physician office visits, home health and respite care, outpatient mental health benefits, and outpatient prescription drugs.

In contrast, in 1985 more than one-half of the uninsured workers were under age 30 and 35 percent were younger than age 25. The fact that this is a younger population suggests that their health care needs are more acute care and primary care in nature than those over age 65. In addition to this being a relatively young population, they have relatively low incomes. Sixty-two percent of the uninsured live in families with incomes below 200 percent of the federal poverty standard -- one-third have incomes below poverty. Even a $300 cost sharing requirement for someone at 140 percent of poverty could be a barrier to health care.

These statistics on the uninsured raise the very fundamental question of how to trade off the need of the uninsured for comprehensive benefits verses the need for affordable overage. We will be examing this issue as part of our ongoing work on how to make coverage more accessable to the currently uninsured.

Conclusion

The Blue Cross and Blue Shield Association believes that action must be taken to address the problem of the 37 million uninsured. We are and will continue to pursue enhancing private sector coverage, and believe that we can help solve this problem if we have governmental support to offer more tailored and affordable packages, and tax incentives for certain additional employers to offer benefits. Further, we recommend federal and state actions to meet the needs of those who cannot purchase private coverage, such as low income and high risk individuals.

Once again, we applaud your leadership role in addressing the needs of the uninsured. We look forward to working with the committee on a constructive basis to resolve some of the technical problems we have with H.R. 4951.

Thank you.

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Chairman **Stark**. In your chart you talk about expanding medicaid, but what I hear is that that costs us too much. A lot of States are going to get hit. Perhaps, some just cannot afford it. Some may not want to afford it.

Are you recommending we just go ahead and swallow hard and subsidize Mississippi and Alabama, and those States, New York and California, who have fairly generous benefits get nothing?

Assuming that we have the political ability to pull off something like that. It is well and good to say we don't have the jurisdiction here, but to say let's just put minimum standards on Medicaid that will take care of that, I am not too sure that that is a reality.

Do you have any sense what we ought to do and how Maryland would do something like that?

Mr. **Schramm**. I think, Mr. Stark, there are some statistics which you are probably familiar with that indicate the severity of the problem of financing. I think when I last looked at this which must be a year ago, if you took the Federal matching funds that went to New York and California, they accounted for something like 38 percent of the total Federal matching dollars.

I point that out because at the far end of that scale the lowest 20 States seem to have accumulated less than 20 percent of the Federal matching dollars. I suggest that sooner or later we probably ought to, if we are really going to correct the problem, if we are going to make something of Medicaid and restore the Medicaid vision—we are going to have to deal with that four square.

I am not sure I am competent to speak to the question of per capita affordability. We do know there is lots of evidence that suggests that over time there has been a decay in New York State, for example, of per capita affordability.

Likewise there are States like Texas, for example, which provide a minimal approach, and where, notwithstanding the downturn of the oil business, per capita wealth has increased.

Chairman **Stark**. We have passed this risk pool legislation twice out of this committee, out of the full committee and on the Floor of the House, and we have been handed our lunch in conference by the other body. Who is whipping us? Who really doesn't want risk pools?

Ms. **Lehnhard**. If I can respond by saying in lobbying for more equitable financing at the State level, we encounter opposition from employers who self-fund their health benefits. I am sure they are very concerned about having to subsidize these pools. That may be the same source, I am not sure.

Chairman **Stark**. Do you see they believe they have a better deal if—they don't believe the cost is minimal.

Ms. **Lehnhard**. I think it is cost plus the precedent of coming under State mandates which they enjoy being out from under.

Mr. **Schramm**. I could only echo that.

Chairman **Stark**. Mr. Gradison?

Mr. **Gradison**. Thank you, Mr. Chairman.

What is the attitude under the health insurance industry, if there is an attitude, a point of view, on the possibility of permitting, on a sliding scale, medicaid buying insurance for those above the poverty line?

Mr. **Schramm**. I think it is fair to say that within our group, we talk extensively about that and it is certainly—I am certain I am on firm ground to say it is within the realm of possibility for our support.

Ms. **Lehnhard**. We have formally recommended a Medicaid buy-in up to 150 percent of poverty, although we don't know how it would work.

Mr. **Gradison**. One of my regrets, well, not regrets—there have been procedures underway to see how it would really work out in practice. One doesn't always experiment before putting things on a national basis but it is not a bad idea on something this important.

Another angle to it, of course, some of us suspect if Medicaid were not limited to people who are not very poor there would be more support for improving quality of Medicaid and the adequacy of coverage and level of reimbursement and correcting some of the other problems of the program.

So there could be an indirect benefit in terms of the quality of care for the poor if they weren't the only ones covered by those programs.

Ms. **Lehnhard**. I think breaking the welfare link would also help.

Mr. **Gradison**. Thank you both.

It is a great to have you back here again.

Thank you.

Chairman **Stark**. Thank you.

The subcommittee is in recess.

[Whereupon, at 12:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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Ronald L. Harris, D.C.
Executive Vice President

August 30, 1988

Honorable Fortney Stark, Chairman
Subcommittee on Health
House Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

Representing the nearly 20,000 members of the American Chiropractic Association, I request that this letter be made a part of the record developed as a result the Subcommittee's hearings on H. R. 4951 held on August 9, 1988.

While there is much to commend in H. R. 4951, not the least of which is its basic attempt to satisfy the significant need of millions of working Americans for health-care insurance, there are several aspects of the legislation that not only trouble us but appear to be premeditatively anti-alternative health-care provider in nature.

Many tend to scoff at the so-called "provider issue" associated with the extension of health care benefits as unimportant or, at most, secondary to the actual authorization of services to the beneficiary. The irony of this is that in the same breath that new benefits are being provided to the uninsured, their [the beneficiaries'] access to providers from whom they may seek the care is being limited and denied. Without freedom-of-choice or antidiscrimination features, any legislation which does not define physician and concurrently preempts state laws is simply handing over the provision of services covered by any bill exclusively to medical and osteopathic doctors.

It is critical that services be provided to those who do not presently have access — on that there can be little argument. But it is important, as well, who provides those services and to what extent a beneficiary has a choice of who will provide them. The American Chiropractic Association strongly asserts that any patient/beneficiary must have the unfettered right of choosing their physician.

While H. R. 4951 directs that the benefits it would guarantee workers are those presently covered under Medicare — and that would include only very limited chiropractic benefits -- it not only does not specify which type of practitioner is recognized to provide these benefits, it goes one step further to propose a

"Limitation on Providers" (Section 5000A(e)(2)(F)), to wit:

> "The plan may limit the persons from or through whom benefits are available so long as beneficiaries are provided reasonable access to health care."

We would strongly urge, therefore, that the new Section 5000A(e)(2)(F) of Section 2 of H. R. 4951 be stricken, and the following freedom-of-choice language be inserted in lieu thereof:

> "Beneficiary Freedom of Choice. A beneficiary shall be free to select any state-licensed health care practitioner to render services for the care of any health condition covered by the plan.
>
> (i) The plan shall not discriminate against any class of state-licensed health care practitioner with respect to reimbursement for the care of any health condition covered by the plan when the practitioner is providing such care within the scope of his or her license.
>
> (ii) Nothing in this section shall be considered to supersede or preempt state or local law which relates to the licensing of a health professional."

It seems to us that the federal government ought to be promoting the use of the widest possible range of state-licensed health care providers, and encouraging federal beneficiaries to seek out less-costly, alternative health-care providers, rather than limiting from whom they may seek care to only MDs -- which certainly would be the case under H. R. 4951.

If a chiropractor can legally render the same services as a medical doctor for a condition they are both licensed to treat, why should a beneficiary not have a choice of which one to see -- or, even more importantly, why should a beneficiary be limited to having to see one over the other?

There is no logical, political, or economic excuse for denying a patient the freedom to choose his or her health-care provider. Such a guarantee does not mandate new benefits, it does not require the use of one practitioner over another, and it does not promote increased utilization. In fact, with regard to the use of chiropractors, studies have shown that chiropractic can put a beneficiary back to work sooner and at a lower overall cost than can a medical doctor.

The above provision not only provides for a guarantee of patient freedom of choice, but also addresses another problem associated with the manner in which

HHS currently views the provision of chiropractic services under Medicare. Although a chiropractor is among those providers defined as physicians under Medicare — albeit in a very limited manner — HHS takes the position that chiropractic services may be rendered by any other practitioner currently defined as a physician under Medicare who is licensed to perform them. Due to the MD's plenary license, what this translates to is the withholding of chiropractic services rendered by a chiropractor — particularly in the HMO setting where the gatekeeper is usually an MD. While the plenary license of an MD may allow him to legally render manipulative services, MDs are qualified neither by education nor training to the same degree as a doctor of chiropractic to manipulate. In addition, an MD is not licensed to perform chiropractic services; consequently, any manipulative procedures performed by anyone other than a chiropractor do not constitute chiropractic services.

Your provision "Limitation on Providers" would only exacerbate this problem by allowing plans to effectively "write out" the delivery of chiropractic services by chiropractors, while at the same time enabling them to maintain that other licensed and Medicare-recognized physicians can provide those services — if necessary. And we both know that when left up to a medical doctor, chiropractic services are rarely "necessary." A freedom-of-choice provision will protect the desires of those patients who may presently see chiropractors on an out-of-pocket basis, but who might be denied chiropractic services if only a medical doctor were allowed to render them.

Finally, H. R. 4951 uses Medicare as a model for the benefit package, adding coverage for maternal and child health benefits. As I know you are aware, chiropractic services under Medicare are limited to those "with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist)...." Enacted in 1972, this definition of "chiropractor" as a "physician" under Medicare, and the limitations inherent therein are woefully antiquated.

Both Medicare Part B beneficiaries and certainly the millions of Americans under the age of 65 contemplated as new health-care plan beneficiaries under H. R. 4951 deserve a wider-range of reimbursable chiropractic services than those presently provided through Medicare. In that regard, we would strongly urge you to modify the current definition of "Physician" under Medicare as it pertains to the term "doctor of chiropractic", as follows:

> "Clause (5) of section 1861(r) of the Social Security Act (42 U. S. C. 1395x(r)) is amended to read as follows:
>
> '(5) a doctor of chiropractic, with respect to the provision of items or services described in subsection (s), including the adjustment of the spine and other state-licensed services, which he is legally authorized to perform as a

doctor of chiropractic by the state or jurisdiction in which
he performs them, or'."

In order to assure that chiropractic benefits are a part of the benefits package provided by H. R. 4951 -- which we believe is your intention -- the basic "chiropractic services" provision under Medicare must be modified (as above) and some statutory assurance provided that chiropractic services may be rendered only by doctors of chiropractic.

We appreciate this opportunity to provide input to H. R. 4951 during this session of Congress. We very much would like to continue to work with you in the 101st Congress to provide a minimum benefits package for those presently uninsured which is realistic and which may contribute to lessening the overall cost of the provision of mandated services. Chiropractic is a vital component to that equation, and has a role in any legislation that accords affordable access to health care.

We truly hope that the Congress and specifically your committee -- which offers a more pragmatic approach to the provision of affordable health insurance than many other proposals now pending before the House and Senate -- will not abandon alternative health-care providers in the provision of mandated services. To allow any legislation or any plan fashioned under such legislation to limit reimbursable health-care services to those rendered only by medical and osteopathic doctors ignores the contributions of other participants in the health care delivery system, stifles competition and lessens health-care options for beneficiaries.

Sincerely,

Ronald L. Harris, D.C.

cc: Board of Governors of the American Chiropractic Association
American Chiropractic Association Commission on Legislation
American Chiropractic Association Commission on Health Delivery Systems
Mr. W. Randall Rawson, ACA Director of Governmental Relations

TESTIMONY

OF THE

AMERICAN FEED INDUSTRY ASSOCIATION

Chairman Stark and members of the subcommittee, the American Feed Industry Assn. (AFIA) thanks you for the opportunity to comment on H.R. 4951, mandated health insurance legislation. Within the parameters of that discussion, AFIA would like to specifically address how this legislation would be detrimental to the feed industry and its employees.

AFIA is a national trade association representing the manufacturers of more than 70% of the primary formula poultry and livestock feeds sold annually in the U.S. Our membership also includes those companies supplying animal drugs, ingredients, equipment and services to feed manufacturers. More than two-thirds of our members are small businesses. The industry we represent employs over 100,000 people.

AFIA opposes mandated benefits such as those proposed by H.R. 4951. The basis for this opposition is that mandated benefits are a dangerous and unnecessary intrusion of the traditionally private relations between an employee and an employer.

Maintaining the integrity of the employer-employee relationship is essential to achieving the best package of benefits possible for both parties. Through negotiation, employees can stress the benefits that are most important to them, and employers can explore different ways of meeting those needs so as to minimize cost. For example, single parents often are more interested in daycare benefits than in dental insurance. Many workers feel maternity coverage is unnecessary, but are most concerned about the size of retirement plan contributions. Some would prefer parking privileges to extended leave benefits. These varying needs are currently met thanks to the inherent flexibility of the traditional employer-employee negotiation process.

Such flexibility is desperately needed today considering the changing demographics of the U.S. work force. The increasing number of women who work outside the home and the steep rise in the number of workers who have no children make the need for individualized benefit packages more urgent than it has ever been. To require benefit-specific minimum health insurance coverage restricts the creativity that is essential to meeting the needs of today's work force.

It is important that H.R. 4951 be seen in its true light. This legislation outlines a fundamental change in labor relations which would prevent employees from getting the kind of insurance coverage they need and want.

Decisions as to whether to provide health insurance coverage and to whom, belong in the private negotiation process. Such decisions are made in response to employee needs, premium costs, insurance availability and a firm's ability to provide coverage.

Of particular concern, aside from opposing the basic concept of the legislation, are the following:

1. Paid health insurance benefits for former workers is perhaps one of the most burdensome provisions of this legislation. "COBRA" itself is responsible for increased insurance premiums and countless administrative headaches for firms of all sizes, but particularly for small firms. Forcing an employer to continue coverage for former employees is a key factor in the steady rise in premium costs. These costs may be pushed even higher by a provision in the recently approved technical corrections bill, which requires employers to cover pre-existing conditions even after a worker is re-employed. COBRA and its expansion has never been subjected to formal comment from the business community. This further expansion dramatically increases the costs to firms and has far-reaching ramifications for long-term health insurance costs.

2. Expansive benefits, which surpass the benefits provided by most corporations will drive up the costs of the insurance package and may ignore specialized needs of the firm's employees.

Again, on behalf of our more than 600 member companies, and in the best interest of the 100,000 employees in the U.S. feed industry, AFIA urges the committee to oppose the concept of mandated insurance coverage. Again, Chairman Stark and members of the committee, AFIA thanks you for the opportunity to comment.

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

August 25, 1988

The Honorable Fortney H. Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Re: Statement for the Record of the August 9 Subcommittee Hearing - Providing Adequate Health Insurance for the Uninsured and Underinsured

Dear Chairman Stark:

The American Medical Association is writing to express its views concerning the important issue of providing adequate health insurance coverage for the uninsured and underinsured. The AMA commends you for introducing H.R. 4951, the "Employee Health Benefits Improvement Act of 1988."

The AMA has for some time been concerned with important issues involved in this subject. For example, we support (1) continuation of health insurance coverage for a reasonable period after an employee is terminated, (2) a 100% deduction for the costs of health insurance premiums for all self-employed persons, (3) tax incentives to encourage employers to provide adequate insurance coverage, (4) the establishment of state health care risk pools, (5) the establishment of state indigent care funds, and (6) reform of the Medicaid program to provide uniform eligibility and benefits for all persons below the poverty level.

The enclosed statement focuses on the AMA's proposals to provide adequate health insurance coverage for the uninsured and underinsured. We request that this letter and our statement be included in the record of the August 9 hearing held by the Health Subcommittee concerning H.R. 4951.

The AMA looks forward to working with you and other members of the Subcommittee to address the important issue of providing adequate health insurance coverage for Americans who are uninsured and underinsured. We note that your legislation covers certain of the elements proposed by the AMA and discussed in our statement. We will forward our comments concerning your bill upon completion of our review.

Sincerely,

James H. Sammons, M.D.

JHS/tmw
4079p

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Re: Providing Adequate Health Insurance
for the Uninsured and Underinsured

August 25, 1988

The American Medical Association takes this opportunity to express its views concerning the important issue of providing adequate health insurance coverage for the many Americans who are uninsured or underinsured. We request that this statement be included in the record of the August 9 hearing of the Health Subcommittee concerning H.R. 4951.

Scope of the Problem

Lack of adequate health insurance coverage is a serious problem in this country. Although the exact number of persons who lack health insurance coverage is not known, a recent study by the Congressional Research Service (CRS) estimates that about 37 million Americans had no coverage at any time during 1986. The CRS found that the percentage of persons lacking health insurance has increased from 14.6% in 1979 to 17.5% in 1986. More than half of the uninsured were employed during at least part of the year. About 30% of the uninsured had incomes below the federal poverty level. Another 30% had incomes under 200% of the poverty level.

It is estimated that about 1 million of the uninsured are persons who are considered to be "medically uninsurable.' These persons are either unable to obtain health insurance coverage or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

In addition to the uninsured, millions of other Americans lack adequate health insurance coverage. Thus, while these persons have health insurance, they may still be financially vulnerable and may lack access to necessary health care services.

The problem of the uninsured is heightened by the change to a "prudent buyer" mentality by both public and private sector purchasers of health care. An unexpected result of this redirection has been that cost-shifting, the historically accepted means to finance care for the uninsured, has become more difficult, if not impossible.

Studies already indicate that the uninsured have fewer physician visits, spend fewer days in the hospital, and are less likely to seek medical care when ill. We are concerned that with the U.S. health care system becoming more competitive and cost-conscious, the uninsured will experience increased difficulty in finding access to necessary health care services.

AMA Proposals

While we encourage and commend the impressive voluntary efforts of the many individual physicians across the country who provide charity care, the AMA recognizes that the magnitude of the problem of the uninsured and underinsured makes government action necessary. Because no single approach would adequately address the health care needs of all of the uninsured and underinsured, the AMA has developed a number of state and federal legislative proposals for extending adequate health insurance coverage to unprotected individuals.

State Risk Pools

The AMA strongly supports the enactment of state risk pool legislation that would provide coverage for the uninsured, the underinsured and the medically uninsurable. (Fifteen states already have enacted risk pool legislation to create health associations that sell policies to high-risk, uninsurable individuals. These pools use a variety of mechanisms to make coverage available while spreading the cost of covering the medically uninsurable over a large population.) In our view, persons with incomes above the poverty level who are unable to afford individual health insurance policies but who could buy coverage, if offered, at group rates should be eligible. The pools should provide a specified level of adequate benefits and should set premiums at not less than 110% or more than 125% of the average premium for comparable group coverage by insurers in the state. States should provide publicly funded vouchers on a sliding scale to help those persons with incomes between 100% and 150% of the poverty level pay the premium for pool coverage. About 5 million people would qualify for such voucher assistance. Persons with incomes between 150% and 200% of the poverty level should also be eligible to purchase pool coverage, but at their own expense.

It is likely that the costs of risk pool coverage would not be met totally through enrollee premiums. In that event, risk pool costs in excess of premium income should be spread as widely as possible. The AMA believes strongly that all health care underwriting entities in the state, including commercial carriers, non-profit medical service plans, health maintenance organizations, and self-insured plans, should be required to participate in the risk pool. By having all carriers participate, the pool would be assured a financial base sufficient to support the program and to achieve a fair sharing of the risks. Unfortunately, states currently are prohibited by the Employee Retirement Income Security Act (ERISA) from requiring that self-funded employee benefit plans participate in state risk pools. This prohibition creates strong barriers to effective operation of state risk pools since self-insured plans write over half of the employee group health insurance business.

In order to achieve broad participation in state risk pools, the AMA has developed draft federal legislation that would amend ERISA to require states to regulate self-insured plans in the same manner that other health insurance plans are regulated. Self-insured plans would thus have to participate in state risk pools. The AMA has also developed draft federal legislation that would allow employers to deduct their health insurance premiums only if they purchase group health insurance coverage from an entity that participates in the risk pools. A copy of each of these draft bills is attached to our statement. We urge that these bills be given careful consideration.

The AMA supports the use of state tax revenues as an alternative to assessing the carriers participating in the pools for any excess pool costs over premium income. Using state tax revenues would spread the pool costs over all state taxpayers rather than over only the policyholders of participating carriers.

Establishment of State Indigent Care Funds

We support the establishment of state indigent care funds that would pay providers in proportion to the amount of uncompensated care they render. These funds would be financed from general revenues and would reimburse uncompensated care costs for those who remain uncovered under either state risk pools or through an expanded Medicaid program.

Medicaid Reform

The AMA believes strongly that federal and state governments have a legitimate role in assuring access to medical care for persons with incomes below the poverty level. It is well documented, however, that the current structure for providing most of the health care services for this population group, the Medicaid program, is fraught with problems and major reforms are needed.

We have just completed a thorough study of the Medicaid program. The report on the study was recently approved by the AMA House of Delegates and is attached to this statement. It finds the following major flaws with the Medicaid program:

- no coverage for about 60% of the people with incomes below the poverty level. (About 20 million persons with income below the poverty level are not currently covered by Medicaid because they do not meet categorical or income eligibility requirements);
- wide variation in eligibility criteria from state to state;
- wide variation in benefits from state to state, with underfunding of medical services to finance less beneficial services; and
- grossly inadequate physician and hospital reimbursement levels which serve to restrict access to care.

The AMA report concludes that reform of the Medicaid program should be based on the following principles:

- the creation of a basic national standard of uniform eligibility for all persons below the federal poverty level (adjusted by state per capita income factors);
- the creation of basic national standards of uniform minimum adequate benefits;
- the elimination of the existing categorical eligibility requirements; and
- the creation of adequate physician and hospital reimbursement levels to assure broad access to care.

The AMA is aware that implementation of the above principles would result in a significant expansion in the number of Medicaid beneficiaries and in the amount of state and federal spending under the Medicaid program. In our view, however, no other solution would adequately address the health care needs of the uninsured with incomes below the poverty level.

Temporary Extension of Coverage

Workers who are laid-off should have the opportunity to maintain employment-based health insurance for at least several months after their termination. The AMA supports legislation that would require employers to offer to continue health coverage for laid-off workers and their dependents for up to four months after the lay-off, with the employer and ex-employee continuing to pay the same percentage of the premium they had paid before the lay-off. Enactment of this legislation would encourage laid-off employees to continue their health insurance coverage in their former employer's group health plan because they would not have to pay the full premium. In addition, we support the provisions in P.L. 99-272 that require employers to make group health insurance available for terminated workers at the worker's sole expense for an additional 18 months.

Open Enrollment Period

The AMA supports legislation that would mandate that an employer's group health plan must provide an open enrollment period of at least 60 days for spouses of unemployed workers. In some two-income families, only one spouse may be enrolled in a group health plan. Currently, if that spouse becomes unemployed, the whole family would be without health insurance coverage. Enactment of mandated open enrollment legislation would appropriately address this situation.

Deduction for Self-Employed Individuals

Currently, self-employed owners of unincorporated businesses can deduct as a business expense only 25% of the cost of premiums for their own health coverage. Self-employed owners of incorporated businesses can take a full business deduction for their own health insurance premiums if they provide coverage for their employees.

The AMA supports legislation that would allow all self-employed individuals to take a 100% business deduction for group health plan contributions paid for their own health coverage if they provide adequate health insurance coverage for their other employees. Permitting self-employed individuals to take a full business deduction for their own group health plan contributions would encourage them to offer health insurance coverage to their employees and would create parity with incorporated businesses.

Encouraging Formation of Multiple Employer Trusts

The AMA believes the federal government should encourage the increased formation of Multiple Employer Trusts (METs). METs allow small employers to combine their buying power and spread their risks over a larger employee group, and their encouragement should result in more small employers being able to afford to either directly offer or to purchase adequate health insurance coverage for their employees. The AMA recognizes that those states currently not regulating the fiscal solvency of METs would need to enact appropriate legislation. In addition, a mechanism would be needed to ensure that METs purchase or provide adequate benefits. The AMA has developed draft legislation that would provide such a mechanism by amending the federal tax code to make the provision of adequate benefits a condition for an employer to deduct the cost of group health insurance premiums as a business expense. A copy of this draft legislation is attached to our testimony.

Studies of Tax-Supported Subsidies to Small Employers

The AMA believes that feasibility studies should be conducted concerning the effect of providing tax-supported subsidies to small or low-wage employers to assist them in purchasing adequate health coverage for their employees. These subsidies could make adequate health insurance accessible to many workers who are currently uninsured.

Conclusion

The AMA is very concerned about the fact that millions of Americans lack adequate health insurance coverage. The severity of the problem of the uninsured and underinsured makes further federal and state government action necessary. We have developed a number of proposals for extending adequate health insurance protection to the uninsured and the underinsured. Our proposals involve providing coverage through the private sector for the uninsured and underinsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level. We urge the Committee to give careful consideration to the AMA's proposals.

STATEMENT
OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
ON THE
EMPLOYEE BENEFIT IMPROVEMENT ACT (H.R. 4951)

September 22, 1988

The American Society of Internal Medicine (ASIM) takes this opportunity to share with the Subcommittee on Health its views on medical indigence, in general, and H.R. 4951 (The Employee Benefit Improvement Act) in particular. The Society is concerned about the 37 million persons who, for one reason or another, are uninsured or underinsured. Requiring employers to provide insurance to employees is an appropriate and important step in addressing this problem. The Society, however, believes H.R. 4951 should be strengthened to provide 1) greater competition in the insurance industry (and, therefore, choice of insurance for employers and employees), 2) more effective cost-sharing provisions and 3) a cost-effective benefit plan.

ASIM has over 20,000 members who are practicing internists or subspecialists of internal medicine, such as cardiologists, gastroenterologists and oncologists. The Society was founded to address socioeconomic issues, such as medical indigence, that affect the practice of medicine. In every health care setting, with each type of illness, and in every age group and social class, internists encounter patients who do not have any (or adequate) insurance and cannot afford to pay for their health care. This testimony outlines the Society's views on the medical indigence problem, ASIM's recommendations for addressing this problem and specific comments on how requiring employer-sponsored insurance will help address this issue.

MEDICAL INDIGENCE: AN OVERVIEW

Individuals are medically indigent for different reasons: some persons are categorically poor; other persons, because of their health or employment status, are uninsurable; still other persons cannot afford health insurance and are not covered by a group plan; and finally, some people opt out of the health insurance market.

According to a recent study by the Vanderbuilt Institute for Public Policy Studies (Patricia Danzon, Frank A. Sloan, 1987) only 33.9 percent of the uninsured under the age 65 fall below the national poverty level--$5,469.00 for a single person, $10,989.00 for a family of four. For those uninsured persons above the national poverty level, Danzon and Sloan conclude that 19.3 percent have incomes of 100-150 percent above the poverty level, 13.9 percent have incomes between 151-200 percent above the poverty level, and 33 percent have incomes over 200 percent of the national poverty level. While those persons with incomes above the poverty level are probably able to afford some level of health care, their economic resources are often quickly depleted if they require intensive medical care.

Contrary to popular belief, persons employed full-time comprise the largest segment of the population without health insurance. According to the Danzon Sloan study, nearly 60% of the uninsured family heads are full-time employees. Another 20% are part time-employees. Only about 20 percent of the uninsured population are unemployed.

The American Medical Association's (AMA) Council on Medical Services estimates that at least one million persons are medically uninsurable because their health or employment status makes them high risks. The number of medically uninsurable persons, however, could increase dramatically as the AIDS epidemic spreads. Presently 41,000 persons have contracted either the HTLV-3 virus or the AIDS disease, according to the Centers for Disease Control (CDC). By 1991, a little over three years from now, the CDC predicts there will be 323,000 persons who have contracted this disease. Further, although the CDC has not projected the disease rate beyond 1991, it is commonly believed that the epidemic will grow to far greater proportions.

Based on this information, it is only prudent to expect that the AIDS epidemic will put a tremendous strain on the health care system. Since many persons with this disease are uninsured, lose their employment and, consequently, lose any insurance they may have or exhaust their insurance coverage, the epidemic has to be an important part of the Subcommittee's overall consideration.

It is likely that the medically indigent population will grow dramatically over the next number of years. The most significant reason for this increase will be the expanding elderly population. Based on census information, we know that increasing numbers of persons will be reaching the age of 65 or older. Further, due to better medical care, the number of persons over the age of 85 will also be increasing. As elderly patients live longer, they generally require increasing amounts of medical and nursing care. Conversely, individual's resources are gradually depleted and eventually exhausted as they live longer, particularly as their nursing and medical needs increase. According to Arthur Anderson and Co. ("The Future of Health Care: Changes and Choices," September, 1987), the aging of America is projected to be the number one health care issue by 1995. This change will put even greater strains on Medicare, Medicaid and other health care programs.

ASIM RECOMMENDATIONS FOR PROVIDING COVERAGE FOR THE MEDICALLY INDIGENT

Since medical indigence is a multi-faceted problem, ASIM supports several solutions that address the different reasons for medical indigence. Specifically, the Society has developed separate policies for providing health coverage to the medically uninsurable, categorically poor, and employed uninsured.

Risk Pools

Risk pools should be established for persons who are either medically uninsurable or standard risks who can afford but lack access to group coverage. Risks pools are generally state established insurance entities, comprised of all the state's insurers, that provide health care coverage to the medically uninsurable under regular insurance plans. A cap is placed on the maximum amount that the risk pool association can charge insureds for their health care premiums, and insurers must make up the difference between the revenue generated from premiums and the health care costs under the program. Presently, twelve states have established risk pools: Connecticut, Florida, Iowa, Illinois, Indiana, Maine, Minnesota, Montana, Nebraska, North Dakota, Tennessee, and Wisconsin.

ASIM believes that risk pools are an effective way of providing health care to the uninsurable. Although risk pools normally run a deficit simply because their insured populations are high risks and the premiums are capped (to protect the insured's out-of-pocket costs), ASIM believes that this is an appropriate mechanism through which the medically uninsurable can contribute to their health care coverage and minimize the amount of coverage that society must subsidize.

ASIM believes that all health plans operating in a state should be required to contribute to the risk pool. In some states, alternative delivery systems have been excluded from such programs, and in all states self-insured employers are precluded from being required to participate in risk pools because of exclusions under the Employee Retirement Insurance Security Act (ERISA). ASIM believes that all insurers (health maintenance organizations and self-insured plans) should be required to participate in these programs so that the burden of insuring the uninsurable is spread evenly over society. Therefore, the Society recommends that ERISA be amended so self-insured plans are not precluded from participating in risk pools.

Medicaid Expansion

The Medicaid program should be substantially revised to more adequately meet the needs of the categorically poor. Medicaid is by far the largest program providing medical funding for care of the categorically poor, but its coverage of the medically indigent has declined over the years. Presently, fewer than 38 percent of those persons below the national poverty level receive assistance under Medicaid. Part of the reason for this is that increasingly large portions of the Medicaid budget have gone to the aged, blind, and disabled. In 1983, 37 percent of Medicaid expenditures went to the aged, 35.1 percent went to the blind and disabled, and less than 28 percent went to the poor.

The Society believes that Medicaid is underfunded and poorly organized. As a result, there are large disparities among state programs, inequitable and inadequate reimbursement for many covered services and generally lower levels of care for Medicaid recipients than for other insured persons. To address these problems, ASIM supports several recommendations proposed by the Health Policy Agenda for the American People (HPA) for expanding/enhancing the Medicaid program. The HPA was a multi-year initiative in which over 425 representatives from 172 different health, health-related, business, government and consumer groups evaluated the major health issues facing society and developed recommendations for addressing those problems. The HPA recommendations for increasing the effectiveness of Medicaid are as follows:

- Medicaid should be revised to establish national standards that result in uniform eligibility, benefits, and adequate payment mechanisms for services across jurisdictions.
- Medicaid eligibility standards should be expanded to include the medically indigent, i.e., those needy individuals who are not eligible for Medicaid because they do not belong to a categorically needy group. Payment for Medicaid benefits for the medically indigent should be based on their ability to pay.
- Delivery and payment mechanisms in the Medicaid program should be subject to a "test of performance" criteria to ensure that they are sufficient to guarantee appropriate access to quality and cost effective care.

ASIM believes that these revisions of the Medicaid program are essential if Congress intends to ensure that the poor are provided adequate medical coverage. In addition, the Society supports other changes that will enhance the Medicaid program. For example, ASIM believes that the Medicaid program should have a buy-in provision for those persons who are poor or near-poor so they can be included under a medical plan even though they do not have the finances to purchase one offered on a proprietary basis.

Further, the Society supported the recently-enacted legislation by Representatives Waxman and Schumer to protect spouses from becoming impoverished by spending down their assets in order for their partners to become eligible for Medicaid. ASIM suggests, however, that Congress continue to study additional measures to protect assets of patients and their spouses from being "spent down" in order to qualify for Medicaid.

Finally, ASIM believes a presidential-congressional commission should be established to study the Medicaid program. Such a commission would allow the federal government to more closely analyze problems with the current program and develop a consensus on needed changes. For example, there are wide variations among states in the way services are delivered, i.e., the use of emergency rooms, specialists, alternative delivery systems and other delivery methods that can affect the quality and efficiency of Medicaid recipients' care. Another issue the commission could examine is the impact of Medicaid outlays for long-term care on the availability of health care funds for the categorically poor. As mentioned, only a small portion of Medicaid funds are spent on health care for the poor. A third issue the commission could study is the variations among states in recipients' eligibility for program benefits. For instance, in many states Medicaid is an all or nothing benefit, thereby restricting individuals with marginal incomes from receiving assistance under the program. A presidential-congressional commission is needed to investigate these and other Medicaid issues.

Employer-Sponsored Insurance

Congress should enact legislation to require employers to provide employees with health coverage. Although expanding Medicaid and establishing risk pools will help provide health care coverage for the categorically poor and the medically uninsurable, these policy changes do very little for the 66 percent of the uninsured with incomes over the national poverty level. Therefore, ASIM supports legislation that requires employers to provide health insurance coverage to their employees.

ASIM believes that mandated coverage is presently the most viable option for insuring the employed uninsured because it would (1) cover a majority of the uninsured, (2) eliminate much of the present cross-subsidization of health coverage, (3) provide more appropriate coverage of high-risk individuals, and (4) place all employers under uniform health insurance requirements.

Aside from providing insurance to the largest portion of the uninsured population, mandated coverage will also eliminate insured workers' subsidization of uninsured workers' health care by placing the responsibility of insuring those individuals on their employers. As the Subcommittee is probably aware, much of the cost of providing care to the uninsured is presently shifted to those businesses or patients who can and do pay for their medical coverage.

Further, requiring employer-sponsored insurance could provide a systematic and more affordable means for insuring high-risk individuals. Two other current proposals before Congress (S. 1265 and H.R. 2508) would divide the country into 6-8 insurance regions (with all employers in those regions required to provide insurance) and would, therefore, provide insurers with a larger insured population to spread the individual costs of high-risk individuals. Similarly, H.R. 4951 would establish qualified state health care pools that also could be used for insuring high risk patients.

Finally, while mandated insurance coverage may place a financial burden on some employers, the burden would be one that would be placed evenly on all employers, eliminating current inequities in the marketplace with respect to insurance costs. ASIM also believes this financial cost will benefit employers to some extent by providing them with a healthier and more productive work force.

Although ASIM supports the concept of requiring employers to provide health insurance, the Society believes that any such legislation must meet several specific criteria. First, mandated coverage must allow competition among all insurers to provide businesses a pluralistic choice of insurance options, rather than limiting the number of insurers who can compete for the market.

Second, any mandated insurance must have cost sharing features that are tied directly to medical inflation. Cost sharing is an important incentive for encouraging appropriate utilization of services. If those incentives do not keep pace with medical inflation, the cost sharing feature will not reflect the true costs of the services and will ultimately undermine the effectiveness of the cost sharing incentives.

Further, mandated coverage must have an economically viable benefit structure that includes realistic but adequate levels of inpatient, outpatient, primary care and catastrophic coverage. If the required benefits are too generous, insurance will be unrealistic for employers to afford. Conversely, if benefits are too limited, insureds will not be properly covered. To help ensure that benefit levels are appropriate, the Society believes that insurers and businesses should be allowed to establish actuarially equivalent packages so they can develop competitive but unique plans that back employees' individual needs.

Finally, the Society supports legislation, such as S. 1386 or H.R. 3005, that would extend similar tax benefits to unincorporated businesses for their health insurance costs as those benefits presently enjoyed by large business. (As the subcommittee is probably aware, owners of unincorporated businesses are able to deduct only 25 percent of their personal health coverage costs, thereby making it financially more difficult to purchase insurance for themselves and discouraging them from obtaining coverage for their employees.) Since requiring small employers to provide medical coverage may have an economic impact on them, ASIM believes they should be provided with tax reductions to help alleviate any burden such legislation would place on businesses.

Given these criteria, ASIM, has some specific suggestions for improving the Employee Benefit Improvement Act (H.R. 4951):

- The economic impact of requiring insurance coverage is widely disputed. Congress should carefully evaluate the specifics of H.R. 4951 -- particularly the scope of benefits that would be considered "minimum" benefits -- to assure that they strike an appropriate balance between providing adequate health insurance coverage and minimizing the potentially adverse economic impact on small businesses. Further, ASIM would encourage the Committee to look at revising the benefit requirements so that employees could provide actuarially equivalent plans. This change would give employers and insurers more flexibility in developing a qualified insurance package. One option for doing this would be to set a specific minimum dollar amount that plans must cost and then allow employers to choose what benefit packages are the most economical and beneficial for employees within that dollar level.
- The deductibles and other out-of-pocket expenses under H.R. 4951 are indexed to the overall CPI, thus allowing historically higher medical inflation to erode their cost-sharing value. The Society believes cost sharing should be indexed to the medical component of the CPI to more accurately reflect medical costs.

Tax Incentives

ASIM supports changes in the tax code that would encourage small businesses to provide health coverage for their employees as an interim solution to addressing the medical indigence problem. ASIM believes that the current small business tax provisions make it financially difficult, if not impossible, for some small employers to provide their employees with health care coverage. Revision of the tax code would help alleviate this problem.

Despite the philosophical attraction of using tax incentives to address this problem, the Society does not believe that such reform in and of itself will completely address the medical indigence problem. Rather, ASIM believes tax incentives should be used in conjuction with or as an interim step toward requiring businesses to provide insurance for their employees. Following are some of the specific limitations of tax incentives without other reforms addressing the medical indigence problem:

- There are no data available to demonstrate the impact of expanded tax incentives. Although tax credits or deductions would certainly make employer- or employee-sponsored insurance more attractive, particularly for businesses that do not currently enjoy full tax deductions for employee health coverage, no research has been done that indicates how many additional persons would benefit from such a program. Those persons most likely to take advantage of the program, however, would be the marginally indigent who are employed and may be able to afford private plans. Poor or near poor individuals, however, would be less likely to be helped under an incentive program.
- Tax incentive programs do not provide a systematic way of covering high-risk individuals. Under such programs, employers (especially small businesses) still are faced with the dilemma of insuring high-risk employees. Employers seeking such insurance in the current marketplace would have to either pay high premiums or discriminate against hiring high-risk individuals. (This problem is likely to be exacerbated with the increase in AIDS.) By comparison, required insurance coverage provides a mechanism (regional insurers) through which employers can pool their high-risk individuals among a larger insured population, thereby making the cost of insuring those individuals more affordable.

- Incentive plans do not make health coverage an explicit cost of doing business. Consequently, those businesses that refrain from providing health insurance have a competitive advantage in providing cheaper products or services and, by opting out of providing coverage, shift the responsibility of providing health care to those employers that do provide coverage. Such cost shifting artificially raises the cost of insurance to those companies that presently provide insurance.

- Tax incentives will result in a revenue shortfall for the federal government without a comparable budget savings. Since employees most likely to receive health benefits under a tax incentive program probably do not receive benefits under existing federal health care programs (Medicare/Medicaid), the tax incentives would limit available funds for health care coverage of those who cannot afford coverage.

Conclusion

ASIM commends Chairman Stark for developing this proposal and initiating discussion on the important issue of medical indigence. Medical indigence is a complex problem that will require multi-faceted approaches to adequately provide care to the uninsured and underinsured. One important step in providing health care to the uninsured is to require employers to provide health care coverage to their employees. Although H.R. 4951 is designed to do this, ASIM believes (1) the cost-sharing features of the plan should be attached to the medical component of the CPI), (2) the economic impact of the proposal needs to be more carefully evaluated to ensure that it provides adequate coverage with a minimal impact on small businesses, and (3) the required benefits should have more flexibility so that employers can purchase actuarially equivalent plans.

ASIM also encourages the Subcommittee to consider other complimentary solutions to the medical indigence problem. Specifically, the Society supports expanding the Medicaid program to provide uniform national coverage standards, establishing buy-in provisions for the near poor and developing broader eligibility standards for the poor. The Society also believes a presidential-congressional commission should be established to further examine ways to make the Medicaid program more effective. Finally, ASIM believes Congress should provide identical tax incentives to small businesses as large businesses to help alleviate their overhead costs of providing health coverage.

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M-IB-0763

STATEMENT OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

The American Speech-Language-Hearing Association (ASHA) is pleased to have the opportunity to provide our views on H.R. 4951, a bill to amend the Internal Revenue Code of 1986 to require employers to provide health benefits to employees. ASHA represents over 56,000 speech-language pathologists and audiologists throughout the United States. Our members evaluate and treat individuals with communication and related disorders, as well as conduct research into human communication. Speech-language pathologists and audiologists render services in many different health and education settings including private practice, hospitals, nursing homess, home health agencies, comprehensive outpatient rehabilitation facilities, community clinics, and public and private schools.

INTRODUCTION

ASHA agrees with Chairman Stark that action is needed to provide access to health care for all Americans. Today we have a new maxim: if one does not have health insurance, one does not have access to health care or one avoids seeking health care until illness or the results of an accident become more devastating than necessary. The purpose of our testimony is to support H.R. 4951 because the benefits provided by the legislation are a sufficient beginning for adequate health care protection of Americans.

We believe the minimum benefits covered by the legislation are basic because of their foundation in a federal statute that has been developed over a period of twenty-two years. Congress has had opportunity to determine the required benefits for older Americans and, subsequently, a structure of Medicare benefits has evolved which assures appropriate health care and attends to the needs of Americans beyond the services provided by physicians and in hospitals. ASHA's specific interest is to assure adequate access to services for individuals with communication and related disorders and, more generally, rehabilitation services which permit the most independent life for those receiving health care coverage.

Often, the architects of a new minimum health benefits package believe that basic needs are met by physicians' services and by other services provided in a hospital only. This thinking is narrow and flawed, and builds a package that is not only incomplete but counterproductive according to its own goals. If we need minimum health insurance to cover those Americans without access to health care, we need a minimum that will place them back in the work force as soon as possible. The idea of an individual being discharged from a hospital when he or she cannot communicate effectively only brings to mind the question of how that person can function in a job, at home, at school or during any other daily activity. The ability to communicate is integral to a person's safety and well-being, and speech-language pathology and audiology services can maximize this ability.

Even if a person can no longer speak, rehabilitation can determine the appropriate assistive device or alternate mode of communication, which will allow the person to communicate functionally again. For individuals who have communicative difficulty as a result of a head injury, the speech-language pathologist can teach effective strategies to bring the individual to a level of maximum functional communication. Without these services, the person requires more care at home and may even become dependent on others and withdraw from contact with the outside world. These individuals require rehabilitation services and the coverage needs to be in the minimum health insurance package.

We are pleased to find that H.R. 4951 provides for coverage of health care benefits not less in amount, duration, or scope than those provided under Title XVIII of the Social Security Act. ASHA realizes that testimony by Hewlett-Packard and the National Federation of Independent Business opposes specific mandated benefits. The National Association of Manufacturers goes further by stating "the plan design should be directed at meeting truly unbudgetable health care expenses, exclude dental, vision and hearing benefits, and provide exemption from state benefit mandates" (Page 10). Even labor, through the International Union, United Auto Workers (UAW) recommended to the Health Subcommittee the preemption of state laws which require employers purchasing health insurance policies to offer specific benefits or include specific types of providers. The Service Employees International Union testified that a minimum health standard can not provide cadillac benefits but should cover necessary hospital care, physician's bills, diagnostic tests, prenatal and well-baby care.

The purpose of our testimony is to emphasize the need for benefits that are complete and do not leave the insured with a plan that may provide for coverage of services that may permit only partial recovery following a health problem. A brief review of ASHA's efforts to improve coverage of health care services follows. We have taken steps to increase coverage of speech, language, hearing, and related services in government and private health plans because key rehabilitation services have been overlooked by some major insurers and programs. We have worked with Congress to expand benefits for Medicare beneficiaries and federal employees under FEHBP. In addition, we have developed better communication with the business community to explain speech-language pathology and audiology services and to encourage their inclusion in employee benefit plans. A number of employers and insurance plans now offer benefits for communication disorders because they realize the ability to communicate is a basic human need.

Now comes legislation that is meant to ensure improved access to health care for all employees and their dependents. ASHA believes Congress must make certain that needed benefits are not excluded in the development of mandates.

BENEFITS OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY COVERAGE

Rehabilitation services promote the restoration of functional abilities of individuals with physical, communicative, and cognitive impairment. These services are provided not only in hospitals and physician's offices but also in rehabilitation agencies, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, community clinics, private offices and hospices.

ASHA has advocated for coverage of rehabilitation services in the Minimum Health Benefits for All Workers legislation through testimony and through the National Rehabilitation Caucus in cooperation with other rehabilitation professional and provider associations. The rehabilitation process for individuals with communicative, cognitive, or physical impairments comprises a range of services including speech-language pathology and audiology, physical therapy, occupational therapy, rehabilitation nursing, assistive device technology, home health aide, personal care, and physician services. Fortunately, H.R. 4951 would recognize these rehabilitation resources beyond physician offices and hospital-based rehabilitation services.

According to the National Rehabilitation Caucus, quality health care includes a broad spectrum of hospital, home and community-based rehabilitation services and rehabilitation services are tailored to the unique needs of the patient. Access to a range of services in a variety of settings maximizes an individual's opportunities to receive timely and appropriate care.

If coverage were limited to hospital and physician's office settings, the legislation would seriously jeopardize employee access to quality service alternatives in the home and community. This strategy fails to consider the trend toward shorter hospital stays, which has shifted a significant amount of intensive rehabilitation care to settings other than hospitals. Physician's offices often lack the range of services needed for complete rehabilitation services which are found in community clinics and comprehensive outpatient rehabilitation facilities. Services such as speech-language pathology and audiology may be available only in an independently practicing speech-language pathologist's or audiologist's office. Furthermore, limits on access to health care for workers and their dependents with serious illness, injury, or disability, frequently translates into less than optimum recovery.

Early access to rehabilitation services often prevents the development of secondary physical or psychosocial problems, which can have a detrimental and enduring influence on an employee's recovery. If rehabilitation is provided during critical periods in the recovery process, the immediate and long-term effects will be greater than those from the same rehabilitation services provided after such critical periods.

For these reasons, ASHA believes the scope of benefits covered by H.R. 4951 should continue to include those in the Medicare program in order to ensure that those covered under the legislation have the opportunity to receive services in the most appropriate setting for their personal and health needs. At a minimum, rehabilitation services in hospitals should also be covered in home and community settings.

GROUP HEALTH INSURANCE PLANS COVER REHABILITATION

A substantial share of employee health plans include coverage for rehabilitation services. For many employers, the impetus for including this coverage is based on the recognition that the relative cost of rehabilitation is preferable to the high costs associated with long-term worker disability.

From 1985-1986, the Institute for Rehabilitation and Disability Management (IRDM), a joint venture between the Washington Business Group on Health and the National Rehabilitation Hospital, conducted a national survey of 400 major employers. Among the significant findings were that:

- Sixty-five percent of the surveyed companies pay for rehabilitation services in community hospitals, while 61% reimburse for services in rehabilitation specialty hospitals;
- Seventy-two percent pay for outpatient rehabilitation services; and
- Fifty-three percent reimburse for home-based rehabilitation services.

Therefore, a minimum benefits package that would exclude rehabilitation services in settings other than hospitals could undercut benefits currently provided by most major employers.

In addition to the broad coverage extended to rehabilitation services in federal health programs, such as Medicare and Medicaid, there is a precedent for federally mandated health coverage that includes rehabilitation. Under the Health Maintenance Organization (HMO) Act of 1973, regulations require that certain rehabilitation services be available to enrollees. Additionally, the Group Health Association of America reported in their 1987 "Survey of HMO Industry Trends" that over 91% of HMO plans offer benefits for communication disorders that are delivered by a speech-language pathologist.

STATE MANDATES

Consumers and professionals alike have worked to expand benefits for insurance coverage of services related to communication disorders at the state level. This process is difficult, time-consuming, and has required states to recognize the need for group insurance policies to include coverage of services for individuals with communication disorders. Section 2 would create a new section in Chapter 47 of the Internal Revenue Code of 1986 that would preempt state laws that prevent employers from offering coverage under a group health plan that meets the requirements of this section. Subsection (e) (7) of the required coverage under the plan states:

> This section shall supercede State laws insofar as they may now or hereafter prevent an employer from offering coverage under a group health plan that meets the requirements of this section.

What remains unclear, however, is whether this section would preempt state health insurance coverage mandates. If state coverage mandates are preempted, and if the current legislation were amended to limit coverage below that which Medicare covers, individuals with disability would lose important coverage that presently exists. We believe it is important that this section be clarified so that it is understood how rehabilitation mandates would be affected by this legislation.

STATE REGULATION

Under the present exemption of health insurance requirements from the Employee Retirement Income Security Act of 1974 (ERISA), states have been able to mandate specific health benefits which must be included in group health plans sold in a state. They also have been able to regulate the health insurance industry. Individuals or groups who object to provisions in their health insurance policies relating to the extent of coverage now have a government agency to turn to if an insurance company refuses payment for what appeared to be a covered health service. Who or what will the policy holder be able to turn to if the ERISA preemption is eliminated? Will a service be available through an office of the Public Health Service at regional or state levels? Will there be coordination of health insurance among the offices of state insurance commissioners and the Department of Health and Human Services?

ASHA is aware that some organizations speaking on behalf of the business and manufacturing community have said that one of the few good features of the bill is the elimination of the ERISA preemption. They have requested that this be the only section of the bill that becomes law. The state coverage mandate policies which so many advocates have worked to get accomplished have now become the target of elimination by some in the business community.

It is important to consider the reasons state governments have enacted such group health insurance mandates. Some health insurance plans offered a panoply of benefits while others did not. In addition, some persons have been surprised to learn how many services are not covered when they submit a claim for payment. Therefore, a lack of uniform minimum coverage was the reason behind many of the efforts to get rehabilitation services mandated. A departure from the concept of traditional hospital and physician only coverage was re quired. Moreover, hospice care and home health care offered less costly alternatives to hospital care so state mandates responded to those realizations.

Today, the possibility of eliminating important health insurance benefits in many states by amending the Employee Health Benefits Improvement Act of 1988 is disconcerting. ASHA is aware that a considerable number of state-mandated benefits for rehabilitation services provided by community and home based providers would be decreased to nothing by amending H.R. 4951 in response to testimony by the business community.

States mandating or covering home health services which include rehabilitation services are:

Arizona
California*
Colorado*
Maine*
Montana
New Jersey
New Mexico*
New York
Vermont*
Washington*
Wisconsin

(*indicates insurance company must offer or make available)

Additionally, insurance companies in Maryland, Montana, and Nevada are required to include hospice benefits in their plans. These desirable, humane, and cost-effective mandates would be eliminated too.

We reiterate that Section 2 of the legislation should be clarified in order to ensure that state rehabilitation mandates would not be eliminated. Any such legislative change would adversely affect access to services. Consider the following examples: Colorado and Maryland may no longer have mandatory coverage of oral and facial surgery, orthodontic and prosthodontic treatment or habilitative speech-language pathology services for children with cleft lip and palate. Mandatory coverage for disabled children in Michigan also could be eliminated. Pennsylvania's mandatory coverage of physical therapy and the mandatory option for speech-language pathology and audiology services in Texas, Missouri, and Arkansas could be lost.

RECOMMENDATIONS

The American Speech-Language-Hearing Association believes that minimum mandated benefits must include access to rehabilitation services in all settings because of the

(1) importance of rehabilitation services,

(2) cost-effectiveness of the services,

(3) prevalence of current group health coverage of rehabilitation services, and

Therefore, we make the following recommendations:

- ASHA recommends that the coverage currently required by H.R. 4951 be continued as is.

- Committee report language should describe the importance of rehabilitation services found in the Medicare program and describe them as including speech-language pathology and audiology, physical therapy, occupational therapy, and services rendered in home and community based settings.

- Section 2 of the legislation should clarify how any preemption would affect coverage that is already state mandated but different than that under Title XVIII of the Social Security Act.

We believe rehabilitation services, including speech-language pathology and audiology, will effectively provide access for most of the employees for which the legislation is intended to assist. The absence of coverage for needed rehabilitation care could jeopardize employee's health and subject them to the risk of more serious and costly health problems in the future. Ultimately, passage of a minimum health benefits law providing for rehabilitation services beyond the hospital and serving the health care needs of the American worker is in the best interest of employers. H.R. 4951 may ensure savings for governmentally financed programs such as Medicaid, Medicare, and others because they will no longer be needed as the last resort for assistance to individuals who initially did not receive proper care.

CONCERNED ALLIANCE OF RESPONSIBLE EMPLOYERS
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STATEMENT OF

CONCERNED ALLIANCE FOR RESPONSIBLE EMPLOYERS
(C.A.R.E.)

Before: House Ways and Means Subcommittee on Health
Subject: H.R. 4951
Date: August 17, 1988

On behalf of the 11 million employees represented through the corporate and trade association members of the Concerned Alliance for Responsible Employers (C.A.R.E.), we are submitting this statement of opposition to H.R. 4951 for the record.

C.A.R.E. is a coalition of 140 organizations, which is actively seeking to preserve the voluntary system of benefit structuring which allows employees and employers to determine which benefits are best suited for their individual and mutual needs. Overall, CARE's members directly represent a wide range of businesses and professionals, including manufacturing and service sectors, wholesaler-distributors, retailers, the food and restaurant industry, personnel administrators and hundreds of thousands of small to mid-size firms across the country.

C.A.R.E. opposes mandated benefits such as those proposed by H.R. 4951. The basis for this opposition is that mandated benefits are an unnecessary intrusion on the traditionally private relations between an employee and an employer.

Mandating that employers provide health insurance, and a health insurance plan of a specified caliber, represents a fundamental change in labor relations. Decisions as to whether to provide health insurance coverage and to whom belongs in the private negotiation process. Such decisions are made in response to employee needs, premium costs, insurance availability and the firm's ability to provide coverage. These types of decisions are, by necessity, individuated.

Moreover, minimum labor standards do not address the fundamental issue of access to health care -- an issue that gets lost in the discussion concerning coverage. To meet access problems, the Committee must look at the problems of cost and delivery, not package components.

Of particular concern, aside from opposing the basic concept of the legislation, are the following:

1. Paid health insurance benefits for former workers is perhaps one of the most burdensome provisions of this legislation. "COBRA" itself is responsible for increased insurance premiums and countless administrative headaches for firms of all sizes, but particularly for small firms. Forcing an employer to continue coverage (and now under the recently approved Technical Corrections bill, to also cover pre-existing conditions even after a worker is re-employed) for former employees is a key factor in the steady rise in premium costs. COBRA and its expansion has never been subjected to formal comment from the business community. This further expansion dramatically increases the costs to firms and has far-reaching ramifications for long-term health insurance costs.

2. Expansive benefits, which surpass the benefits porvided by most corporations (TE & C 88), will drive up the costs of the insurance package and may ignore specialized needs of the firm's employees.

3. Loss of cost containment flexibility through the limitations on deductibles, co-pay and out-of-pocket expenses.

4. A far-reaching definition of part-time worker that does not conform to any industry standard. The mandated inclusion of workers on the job less than 18 hours a week will undoubtedly reduce the number of part-time positions available due to the increased costs of employment. Further, this provision seriously hampers a firm's ability to hire seasonal workers to cope with peak work flow periods.

5. Regional risk pools are not a viable solution to the coverage problem. Rather than increasing access to health insurance, regional risk pools will drive up the cost of health insurance for the very firms that are having difficulty obtaining insurance in the first place. The risk pools could also prove to be difficult to administer, resulting in a federal government bail-out as the pools increasingly suffer from adverse selection problems. Moreover, establishing risk pools places the government in the position of handing out monopoly rights, stifling possible innovation and new competitive alternatives.

6. The administration of the tax credit provision, by the employer, will be administratively burdensome and costly, as well as a significant drain on a firm's cash flow. By not addressing the employer's legal liability, small firms will also likely suffer from legal suits and challenges.

Despite our opposition to federally mandated health insurance benefits, C.A.R.E would like to commend the Subcommittee for addressing two important inequities: the proliferation of state mandates and deductibility for the cost of insurance premiums for the self-employed business person.

The provisions calling for the federal pre-emption of costly state mandates and 100% deductibility of the cost of health insurance premiums are important alternatives to mandating health insurance and would go a long way towards addressing the problem of the uninsured in this country.

The C.A.R.E. coalition would like to thank the Subcommittee for the opportunity to submit its views on mandated health benefits.

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WALNUT 2-5252

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Fortney P. Stark, Chairman
Subcommittee on Health,
Committee on Ways and Means
United States House of Representatives

Dear Mr. Chairman,

Re: H.R. 4951: Mandatory Health Insurance
and/or Risk Pooling

This testimony is offered in response to your invitation for public views on mandatory employer health insurance benefits and contributions to a health insurance risk pool. Testimony at the August 9 hearing covered many essential issues in this problem, and described most economic interests likely to be provoked. However, I am moved to further testimony through observation that three important issues were unmentioned, and by reflection that the provider community is likelier to encounter some aspects of the health problems of the uninsured population than are employers, unions, and insurors. Consequenty, Congress might possibly act on this matter without recognizing that risk pools are a far better idea than mandatory employer benefits, should be separated from that issue, and enacted non-controversially without the handicap of linkage.

The Uninsured Residual Portion of the Population Have Disproportionately High Health Costs. There has been a tendency to assume the cost of extending health insurance can be anticipated by merely counting the affected residual population, and multiplying by the existing average cost. Congress should defintely spend money and take time to measure the unique needs of the uninsured group. However, it can safely be assumed this group contains a disportionate number of chronic illnesses, of preexisting illnesses, of deferred or neglected health costs, and a disporportionate number of persons lacking in the background and experience to take advantage of health services available to them — regardless of cost. It is also clear that marketing costs are greater for small groups than large ones, and that administrative costs are higher for employees who change jobs or addresses frequently. Employers with marginal profits will default on premiums more frequently, change benefit packages more often, and shop around for bargain insurors more frequently than do large prosperous employers. Insurance companies prefer to avoid small-group business because, although their costs are definitely higher, they generate heavy pressure to be charged standard rates.

In national legislation mandating employer coverage, the same issue is certain to arise. Large employers are certain to experience pressure to absorb excess costs of the new small groups; it is probably fair that they should do so, and most of them would probably be willing to pay a reasonable surcharge. Such a surcharge could probably be regarded as a tax for the privelege of skimming off the healthy component of the work force, leaving hardship cases to the small entrepreneurs. However, if the surcharge proved to be extremely heavy, large employers would rebel and expect a portion of the cost to be absorbed through general tax revenues, and that is also fair. They would make the point that being a large employer is not necessarily the same as being a profitable one.

It thus becomes critical to know the degree of adjusted extra cost per person of the uninsured population. There are indications that it may be extremely large, and the 1966 experience with Medicaid and Medicare casts grave doubt on anyone's ability to analyse it in advance. If indeed the aggregate cost proves to be very large, there will need to be a nationwide debate about the equity of who should pay for it.

Health Care is Partly an Economic Investment, Partly a Basic Need, and Partly a Consumption Item. The very large costs we are contemplating can be seen to some degree as increasing the productivity of the work force, and consensus would probably be readily forthcoming for public tax support for that purpose. However, perceptions would surely be widely variable about how to separate essential medicine from luxury medicine. At the margin, many patients would themselves disagree about preferences between achieving health, and consuming health services. There is not the slightest doubt that elected representatives would prefer to have any negative decisions be made by physicians, as is true to a large extent in Great Britain.

Robin Hood No Longer Has a Hostage. It is unlikely that many people outside the provider community are aware that tertiary care was associated with teaching hospitals, and that teaching hospitals were once firmly linked to charity care. This three-way linkage made cost-shifting feasible, since the prosperous members of a community could not escape going to charity hospitals if they wanted tertiary care. Forces in the last thirty years, mostly Congressional in origin, disrupted this linkage of tertiary care to charity, and consequently allowed the middle class to seek out hospitals with no charity costs to shift. Therefore even those few teaching hospitals which wish to continue a charity mission are caught in an unbearable price sqeeze by their competition. The time is at hand when Congress must take steps to prevent major disruptions in the health care delivery process. The necessary steps should involve some mechanism for spreading charity costs over a wider geographical area than just the urban ghettos, extending costs to hospitals which are not themselves delivering charity, and to employers who are not themselves disposed to it.

Risk Pooling is the Way to Begin to Sort Out These Issues. At the August 9 hearings, there was discussion of the desirability of addressing unmet health care needs which have not reached the surface. Unfortunately, it is disquieting to achieve this goal by issuing blank checks, since the monthly bank statement may prove to be a shock. Society should first see if it can afford, and if it can effectively administer, a program aimed at the known costs and the least debatable needs. Risk pooling builds on the decisions currently being made by patients, hospitals and physicians. It pays for necessary health care without requiring health insurance for those, like illegal immigrants, who cannot reasonably obtain it. If patients are willing to ask for charity, and providers are willing to give it, the traditions of our culture are such that the absolute minimum benefits package has been effectively described. Both patients and providers will immediately expand their demands if the minimum is satisfied, and it is surely true this is not enough. If the country is willing to afford more, let the benefits package be expanded later, but surely it is inhumane to withold this much while waiting for perfection.

Risk pooling is possible in a number of different ways. The provisions of this bill utilize the method of taxing employers. This has the great advantage of relieving willing state legislatures of the obstacle created by the ERISA that placing taxes on state-regulated health insurors creates an incentive for employers to escape to self-insurance. However, applying the surcharge for the pool to hospital bills would work as well, and would have the advantage of driving some services out of the inpatient area when the outpatient area would be a cheaper alternative. A hybrid tax might achieve both subsidiary goals.

Unlike the untested concept of mandatory employer health insurance, risk pooling of health insurance has been in existence in a number of states for a number of years. Indeed, it would probably now be widely employed if the ERISA had not been enacted; there is no doubt the insurance industry immediately lost its taste for pressing state legislatures for risk pooling. Risk pools can take a number of forms, and it is desirable that a wide variety of pools should be tried in the "laboratories of the states". Congress should adopt a minimalist approach: the main need is to stop preventing the states from forming risk pools.

Respectfully submitted,

George Ross Fisher

TESTIMONY OF
JOHN C. LEWIN, M.D.
DIRECTOR
HAWAII STATE DEPARTMENT OF HEALTH

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES HEARING
ON
H.R. 4951
THE EMPLOYEE HEALTH BENEFIT IMPROVEMENT ACT OF 1988

As Director of Health for the State of Hawaii, I oversee a department that provides a wide range of public health, hospital and outpatient services to the people of the State of Hawaii. Included in these services are services provided by counties or local governments in most mainland jurisdictions. In fact, we are the oldest (first) and the largest health department in the United States. As such, provision of health care for Hawaii's medically indigent is both a state and a statewide responsibility, and is the top health priority for our department. It is for this reason that I am testifying today with respect to HR 4951, the Employee Health Benefit Improvement Act of 1988.

The development of this bill is a major policy decision for the federal government, a decision which has many implications for both the private sector health providers and the public sector which often provides for indigent care. Your measure recognizes an important fact, that many people in the United States have inadequate access to health care because they lack the financial resources to purchase the health insurance that provides the funding mechanism for health care services in America. The large "gap group" that exists in the United States is significant testimony to the fact that we have not adequately provided health care to all members of our society. Without adequate health care, we lack not only social compassion but also long term fiscal wisdom; many preventable health conditions, when not dealt with early, cost the health care system vast unnecessary resources.

The remarks that I am about to make are in no way directed at this important goal that all people ought to be afforded adequate health insurance but rather at some of the specifics of the proposal which we, in Hawaii, feel will negatively impact upon the people of our state. We are most supportive of the intent of this legislation but do differ on some of the particulars.

Our position of difference is based upon the fact that the coverage offered in HR 4951 does not afford the coverage for Hawaii's people as that presently afforded by the state's own Prepaid Health Care Act, passed in 1974. This Act, which requires that each employer provide health care insurance to his/her employees, is landmark legislation not only for Hawaii but for the nation. Through the Prepaid Health Care Act, Hawaii has reduced the percentage of those without health insurance to 5% of our state's population. The people covered by this mandated health care insurance possess a broad comprehensive coverage that provides for adequate hospitalization and outpatient services at reasonable costs that are shared by both the employer and the employee. While our system insures 95% of our population there are still gaps. These gaps consist of: 1) unemployed workers, 2) part-time employed workers under 19 hours a week, 3) workers in certain seasonal occupations, 4) spouses and children of low income workers who elect not to choose family coverage (although there is some disagreement on the size of this population), 5) students, 6) self-employed persons and members of family businesses and 7) persons on commission status in real estate and insurance. We plan to address these gap groups in legislation introduced during our 1989 legislative session in Hawaii. Despite these gaps, we believe that Hawaii has dealt with the medically indigent gap group quite well and has a track record of fourteen years to prove it.

We are thus concerned that this measure, as written, proposes to preempt what we feel is an excellent program for coverage. This preemption will leave our people with less coverage than they now enjoy. We have attached the following to help describe Hawaii's statute and situation: 1) highlights of our law; 2) Hawaii's Prepaid Health Care Act, which includes health care plans having the most subscribers in the state (this will outline the latest coverage available to virtually all of Hawaii's workers); and 3) reports outlining the size and nature of our current 'gap group'.

In recommending specific changes to the legislation, we would like to propose several items for your consideration:

1) An exemption for Hawaii would allow us to continue the meritorious program without retarding development of this needed program in other states. For example, Hawaii's benefits are higher and the deductibles lower than those provided under HR 4951.

2) A second alternative would be to write the legislation so that it did not preempt state action. Federal safety net coverage would remain in place unless states acted to provide a higher level of coverage. States such as Hawaii and Massachusetts have taken the 'bull by the horns' and invested significant time and effort in development of systems to meet the care needs of their people and would thus be assured that their investments would be lost. If such flexibility could be built into this bill (combined with some alteration of the ERISA provisions which limits state actions to require health insurance from employers) we believe an excellent precedent of allowing for state initiatives in this area would be set.

We look forward to elaborating upon our proposals at your convenience. We would be most happy to provide whatever expertise we can in assisting you and your committee to both further analyze our state system of care as well as to develop nationally applicable models.

Thank you for giving us the opportunity to present our views to your Committee. We look forward to working with you to provide adequate health coverage for all Americans.

(ATTACHMENTS 2 AND 3 OF MR. LEWIN"S STATEMENT ARE BEING RETAINED IN THE COMMITTEE FILES.)

Address all inquiries to:

Dept. of Labor & Industrial Relations
Disability Compensation Division

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Lihue, Hawaii 96766
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HIGHLIGHTS OF THE HAWAII PREPAID HEALTH CARE LAW

FOR EMPLOYERS AND EMPLOYEES

STATE OF HAWAII
Department of
Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

Form No. HC-2 (Rev. 8/87)

The information herein is intended to provide employers and employees with a general understanding of the Prepaid Health Care Act. For comprehensive details, please refer to the law (Chapter 393, H.R.S.).

PREPAID HEALTH CARE ACT

Originally enacted in 1974, the Hawaii Prepaid Health Care Act was the first in the nation to set minimum standards of health care coverage for workers. Preempted in October of 1981 by the Federal Employee Retirement Income Security Act of 1974 (ERISA), the Prepaid Health Care Act was reinstated effective March 1, 1983.

The Prepaid Health Care Act requires Hawaii employers to provide health care coverage for eligible employees to insure protection against the high cost of medical and hospital care for nonwork-related illness or injury.

EXCLUDED EMPLOYMENT

Services excluded from health care coverage include but are not limited to: 1) individuals who work less than twenty hours per week; 2) Federal, State, and County workers; 3) agricultural seasonal workers; 4) insurance or real estate salesmen paid solely by commission; 5) individuals working for son, daughter, or spouse; and 6) children under age 21 working for father or mother. (For a complete listing refer to Section 393-5 of the law.)

SECURING COVERAGE

Employers may obtain health care coverage: 1) by purchasing an approved health care plan from a health care contractor or a Hawaii licensed insurance carrier; 2) by adopting an approved self-insured health care plan; or 3) by negotiating a collective bargaining agreement.

Employees may form associations for the purpose of providing health care coverage as long as such health care protection is obtained from an authorized health care contractor.

ELIGIBILITY FOR ENROLLMENT

Employees who work twenty hours or more per week ("regular" employees) for four consecutive weeks and earn a monthly wage of at least 86.67 times the Hawaii minimum hourly wage are deemed eligible. Health care coverage must then be provided to such eligible employees at the earliest enrollment date of the employer's health care contractor.

EXEMPTIONS FROM COVERAGE

Exempt Employees

The following categories of employees are exempt from coverage:

1) those covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents;
2) those covered as dependents under a qualified health care plan;
3) those who are recipients of public assistance or covered by a State-legislated health care plan governing medical assistance; and
4) those who are followers of religious groups who depend upon prayer or other spiritual means for healing.

"Employee Notification to Employer" (HC-5)

To effect an exemption, an employee must complete and submit form HC-5 to the employer who must then file the document with the Department of Labor and Industrial Relations.

The exemption notification is binding for one year and must be renewed every December 31.

CONCURRENT EMPLOYMENT

An employee who works concurrently for two or more employers is prohibited from obtaining health care coverage from each of the employers. The employee is required to designate the principal and secondary employer and file notification (HC-5) with the employers for subsequent filing with the Department of Labor and Industrial Relations. The principal employer shall be the employer who pays the employee the most wages; only in cases where the employer who does not pay the most wages employs the employee for at least 35 hours per week does the employee determine which of the employers shall be the principal employer. The designated principal employer is required to provide coverage pursuant to the law.

An employee's determination of principal employer is binding for one year or until change of employment occurs. Whenever an employee elects to make a change with respect to the status of each, notification (HC-5) must be filed. (For complete details refer to Section 393-6 of the law.)

The employer is prohibited from coercing, interfering, or influencing an employee in making a determination of principal employer.

PREMIUM PAYMENTS

The employer may elect to pay the entire premium amount or share the cost with the employee. The employer must pay at least one-half the premium cost; however, the employee's contribution cannot exceed 1.5% of employee's monthly wages. In the event the employee's allowable share constitutes less than one-half of the premium, the employer is liable for the entire remaining portion. The employer is permitted to withhold the employee's contribution from the employee's wages.

An employee cannot agree to pay a greater share from wages except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents under the same plan.

FILING A CLAIM

The employee should present the health care membership card whenever health care services are rendered.

CONTINUATION OF COVERAGE PROVISION

In the event an employee is disabled and unable to work, the employer is obligated to enable the employee to continue health care coverage by continuing the employer's share of the premium costs for three months following the month during which the employee became disabled, or for the period for which the employer has undertaken payment of employee's regular wages, whichever is longer. The employee must maintain the employee's portion of the premium payments.

HEALTH CARE CONTRACTOR

Type

A prepaid health care contractor may fall in one of three groups: 1) any medical group or organization which provides health care benefits under a prepaid health care plan; 2) any non-profit organization which defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan; or 3) any insurer who defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan.

Selection

The employer selects the health care contractor and the plan type. This election is binding for one year.

HEALTH CARE PLANS

Type

There are two types of health care plans: 1) a plan by which a prepaid health care contractor would furnish health care and 2) a plan by which the health care contractor would defray or reimburse, in whole or in part, the expenses of health care.

Benefits

To meet standards as prescribed by law, prepaid health care plans must include at least the following benefits: 1) hospital (including inpatient care for at least 120 days of confinement in each calendar year), 2) surgical, 3) medical, 4) diagnostic, and 5) maternity. (For further details refer to Section 393-7 of the law.)

Plan Approval

All health care plans must be approved as meeting prescribed minimum standards by the State Department of Labor and Industrial Relations. Such determination is made by the Director under the advisement of a seven member prepaid health care advisory council consisting of representatives from the medical and public health professions, from consumer interests, and from the prepaid health care protection industry.

PENALTIES

An employer who fails to comply with the coverage provisions of the law shall be subject to a penalty of not less than $25, or $1 for each employee for every day during which such failure continues, whichever sum is greater. If such default extends for 30 days the employer's business may be closed for as long as the default continues.

An employer, employee, or health care contractor who wilfully fails to comply with any other provision or any rule or regulation may be fined not more than $200 for each such violation.

APPEAL

When health care benefits are denied a worker, the employer or the prepaid health care contractor must promptly mail a notice of denial to the worker who then has twenty days in which to request a review by the Department of Labor. If the parties are not satisfied by the department's findings, the case will be referred to the Prepaid Health Care Appeals Referee. The decision of the referee shall be final and binding unless the aggrieved party appeals the decision.

SPECIAL FUND

The Prepaid Health Care Premium Supplementation Fund is established by general fund appropriation and used to defray the cost of providing health care benefits for employers with less than eight workers entitled to and covered under the Prepaid Health Care Act. To qualify for premium supplementation the employer must meet the criteria outlined in Section 393-45 of the law.

The fund may also reimburse health care expenses to workers of bankrupt employers and non-compliant employers. Benefits paid from the fund shall be recovered from those defaulting employers.

ADMINISTERING AGENCY

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. For further information please contact the following offices.

Statement of the International Association of Amusement Parks and Attractions (IAAPA)

Statement Submitted To: House Ways and Means
Subcommittee on Health

Subject: H.R. 4951

DATE: August 29, 1988

On behalf of the 1800 member companies of the International Association of Amusement Parks and Attractions (IAAPA), we are submitting this statement for the record in opposition to H.R. 4951.

Our Association represents some 600 fixed location amusement parks and attractions and their many suppliers. While that membership includes all the major corporate park owners in the country, the great majority of our members, over 90% of them, are small family-owned businesses. This is true of both our park members and our supplier members.

Our concern is the effect mandated health benefits will have on small businesses in general, but the seasonal nature of the amusement park industry would make such mandated benefits especially difficult for our members. Neither H.R. 4951 nor any of the other mandated benefit Bills, though they may exempt businesses with very small numbers of employees, deal with the phenomenon of a business which has a large number of employees, mostly students, for a very short period of time.

We would like, therefore, to outline very briefly this rather unique problem in our industry rather than to undertake an exhaustive discussion of all the possible ramifications of mandated benefits for society in general.

Many others have provided you with large quantities of material purporting to show the serious problem such legislation will create. We will not repeat any of that here. We will simply say that we believe those concerns are legitimate, the predicted results are likely and we share a general opposition to the legislation.

Whatever the ultimate disposition of the legislation is, however, we urge you to give attention to the matter of short term seasonal employment.

Very few of our member parks, probably less than 20, operate year around. Ninety-five (95) percent of them, or more, operate three (3) months during the summer plus weekends in May and September and, perhaps, a weekend or two in April and October.

Peak seasonal employment may reach 300 persons in the average park - considerably higher in very large regional parks and substantially below that in smaller parks. Nearly all these summer employees are young persons, working while school is out. The majority will work one season at the park and not return, although some do come back for a second or third season.

Another very important feature of this seasonal employment is its high turnover rate within a single season. Young people very often start work, then leave to take family vacations, go elsewhere, or simply play for awhile before going back to school. It is common for a park with 200 seasonal job openings to actually employ 400 and even more young people over the course of a summer.

The Committee can quickly comprehend the nightmare that would result if a business was required to provide mandated benefits for such employees. Most of them would be off the payroll and back in school or into their next employment before any benefit package would even be processed.

The administrative burden of providing coverage for such a transient employment force would be extraordinary.

The number of full time, year around, employees at most parks is very small. In many, if not most, instances, parks would probably not be covered by the legislation at all if only full time employees were counted because of the thresholds being suggested to exempt very small businesses from compliance.

Counting seasonal employment would result in all parks being covered.

Most of these young people are probably covered by parentally held programs. No good societal purpose will be served by requiring benefit programs for these workers.

It is not engaging in hyperbole to suggest that placing such a burden on employers of such short-term seasonal employees will cause many of them to go out of business.

We therefore urge the Subcommittee to include in its deliberations a thorough examination of this particular problem and to vote against mandating benefits.

Thank you very much for the courtesy of considering our views.

Submitted by: John R. Graff
Executive Director & Counsel

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ABBOTT L. FLETCHER
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IN ASSOCIATION WITH
FIRM RIISE
ØVRE SLOTTSGT 12BIV
OSLO 1, NORWAY

August 29, 1988

WRITER'S DIRECT DIAL NUMBER

347-0294

Robert J. Leonard, Esq.
Chief Counsel
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Employee Health Benefits Improvement Act of 1988
H.R. 4951

Dear Mr. Leonard:

Our office represents the Minnesota Comprehensive Health Association (Association) which provides health coverage for otherwise uninsurable persons through State Plan contracts. I write this letter in response to the public request for written comments regarding the above-referenced legislation.

The Association was established in 1976 as part of the Minnesota Comprehensive Health Insurance Act of 1976 (Act). In about 1977 an application was filed on behalf of the Association with the Internal Revenue Service for recognition of exemption from Federal income taxation as a section 501(c)(4) organization. This application was denied after an appeal hearing before the IRS in Washington, and consequently the Association is treated as a taxable insurance corporation by the IRS.

Although the Association has operated since its inception without taxable income, it is possible that in any given year the Association may have taxable income. In view of the important social purpose for which the Association was established, and for which other risk pools across the country have been established, it appears appropriate that risk pools established for the purpose of providing health coverage to uninsurable individuals be granted exemption from Federal income taxation. We would suggest that such a provision be considered as part of H.R. 4951.

I would call to your attention that in recognition of the fact that the Association was established to promote the public health and welfare of residents of the State of Minnesota that the Minnesota Legislature granted the Association an exemption from all taxation under the laws of Minnesota, which would include an exemption from state income taxation as well as premium taxation. See Minnesota Statutes, sections 62E.10, subdivision 1, and 62E.13, subdivision 10.

It is possible that the Association may have further comments regarding H.R. 4951 after further study by the Board of Directors, and we assume that we may provide additional comments at a later date. Should you have any questions regarding this letter, please do not hesitate to call.

Very truly yours,

John F. Stone

STATEMENT FOR THE RECORD

August 9th Hearing on H.R. 4951, the "Employee Health Benefits Improvement Act of 1988"

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives
Washington, D.C.

Submitted by

Robert H. Sweeney
President
National Association of Children's Hospitals
and Related Institutions
401 Wythe Street
Alexandria, Virginia 22314

(703) 684-1355

On behalf of the National Association of Children's Hospitals and Related Institutions (NACHRI), I want to express our appreciation for the opportunity to submit a statement for the record of the Health Subcommittee's hearings on H.R. 4951, the "Employee Health Benefits Improvement Act of 1988."

NACHRI is the only national, voluntary association of children's hospitals. It represents approximately 100 institutions. Virtually all of NACHRI's members are teaching hospitals and involved in conducting research. Most are also regional medical centers that receive referrals from around the nation and the world.

The breadth and diversity of children's hospitals are visible in the variety of children's hospitals in the home states and regions of the members of the Health Subcommittee. They range from Children's Hospital Medical Center of Northern California in Oakland, CA, to the Children's Hospital in Boston, MA. Some, such as Children's Hospital Medical Center in Cincinnati, OH, are one of several different hospitals in a state. Others such as Arkansas Children's Hospital in Little Rock, AR, or Children's Hospital of Wisconsin in Milwaukee, WI, are the only children's hospitals in their states.

But all children's hospitals have in common their commitment to specialized care for very sick children -- a mission that leads them not only to offer the most sophisticated medical care available but also to serve children of very low income families who reside in the inner-city communities in which many children's hospitals are located.

With this statement, NACHRI seeks to discuss three questions for the subcommittee:

1) Why does NACHRI support the concept of mandated minimum health benefits?

2) Why does NACHRI believe the establishment of a mandated health benefits policy should fit into a more comprehensive system of health care coverage that depends on shared, public-private responsibility?

3) What specific changes in H.R. 4951 does NACHRI recommend for the subcommittee's consideration?

NACHRI's Support for Mandated Minimum Health Benefits

In March 1987 and again in March 1988, NACHRI's Board of Trustees affirmed the association's support for mandating employment-based health benefits for employees and their dependents.

NACHRI's Board has taken this position, while recognizing that among children's hospitals, there will be some which will experience an increase in their operating costs as a result of such a mandate. And any increase in operating expense is a challenge to children's hospitals, given both the large volume of charity care they provide and the inadequacy of Medicaid reimbursement for many of their patients.

However, these costs are outweighed by both the national data documenting enormous gaps in children's health care coverage and the children's hospitals' unique experience with the inadequacy of coverage.

National Data Of the 37 million Americans estimated to be without public or private insurance, 10.6 million were children in 1986, according to the Employee Benefit Research Institute. EBRI reports that nearly "87 percent of uninsured children lived in families with one or more workers. More than one-half of uninsured children lived in families of full-time, full-year workers." In addition, EBRI says, nearly 3.2 million uninsured children in 1986 had families with incomes below the federal poverty level. The children of the working poor, EBRI concludes, "were the least likely to have health insurance."

Children's Hospital Data The shortfall in health care coverage for children suggested by these national data from EBRI is borne out by the experience of children's hospitals, according to NACHRI data analysis.

- Children's hospitals are more likely to see extremely sick children, whose health care bills may exceed their available insurance coverage. Compared to general hospitals' delivery of pediatric care, children's hospitals have on average more than five times the number of cases equal to or exceeding $50,000 in costs; more than 2 times the patient days, and more than 2 times the charges. Similarly, children's hospitals on average have more than twice the outlier patients and outlier patient days as a percentage of their total cases and days.

- Children's hospitals are more likely to care for children of low families, who either lack insurance coverage altogether or have Medicaid coverage whose reimbursement is inadequate. More than a third of the care children's hospitals provide involves children of families who either depend on government assistance for health care coverage or are without insurance entirely. More than a quarter of children's hospital care on average specifically involves children covered up Medicaid -- three times the volume of comparable care on average that general hospitals provide.

- Children's hospitals appear to experience a significant percentage of unpaid-bills among self-pay patients whose families include employed adults. A recent survey of 28 children's hospitals found that more than half estimated that between 70 to 80 percent of uncollected inpatient and outpatient self-pay charges are attributable to families in which at least one parent or guardian is employed.

The inability of many self-pay patients to meet their children's medical bills, despite parental employment, weighs particularly heavily on children's hospitals, because of their Medicaid coverage. On average, more than a quarter of children's hospital care is devoted to children who depend on Medicaid for health care coverage. Yet, nationwide, Medicaid on average reimburses children's hospitals for less than 77 percent of the costs of their care. In other words, for every dollar a typical children's hospital spends to care for a Medicaid eligible child, the state agency reimburses the hospital for less than 77 cents.

Together, these facts on children's lack of insurance coverage in general, the lack of coverage for children with employed parents, and the inadequacy of Medicaid payment for other low income children lead NACHRI to the conclusion that mandated health benefits will be an important part of any national commitment to improve children's health care coverage.

NACHRI's Support for Mandated Minimum Health Benefits in the Context of Comprehensive Health Care Reform

As the national data indicate, the problem of inadequate health care coverage for children can be significantly but not entirely addressed by improvements in the numbers of children of working parents who enjoy employer-paid health care benefits. For mandated benefits to be the most effective, they should be considered and implemented in the context of more comprehensive reform of children's access to health care.

NACHRI specifically supports the development of initiatives that address two specific points:

1) To be effective, efforts to improve health care coverage must serve the different needs of five distinct groups of children without full access to health care.

2) To be effective, efforts to improve health care coverage must build on an explicit public-private partnership, which clearly defines the different responsibilities of the public and private sectors for health care.

Children Without Access NACHRI as well as other child health advocates recognize several distinct groups of children with different health care needs.

- children of low income families who do not qualify for public financed coverage such as Medicaid and/or for whom such programs do not provide resources adequate to children's health care needs;

- children of the working poor, whose employment precludes qualification for public programs, yet does not provide health benefits for dependents, nor results in income sufficient to allow for purchase of health care services or insurance benefits, if available;

- children of working families of modest or moderate income whose employment-provided benefits and personal resources can meet the routine health care costs of their children but are inadequate to meet the cost of catastrophic illness expenses or long-term, continuing chronic illness expenses;

- children for whom limitations in third party benefits result in the child being covered for services in settings which are not the most appropriate for the child's total well-being; and

- children of the temporarily unemployed who lose health benefits as a result of such unemployment.

Public-Private Partnership As the August 9th hearing's panel of witnesses from the State of Massachusetts suggested, there are a number of lessons the Congress can learn from the state efforts to provide universal health care coverage for its citizens. But perhaps the most important lesson is the need for a strong partnership between the public and private sectors. Without investment from both sides, any health care initiative is doomed to fail politically.

NACHRI believes such a partnership must begin with a clear demarcation of responsibilities -- the public sector for the health care of families living on incomes below the federal poverty level; the private sector for the coverage of families with incomes 200 percent or more above the poverty level. For those families with catastrophic health care costs, government and private business must define their shared responsibilities.

Ways and Means Committee's Role The jurisdiction of the Ways and Means Committee obviously does not permit it to act on the full spectrum of legislation that would be needed to solve the health care access problems of all children and to establish a comprehensive public-private partnership.

But within its jurisdiction, the committee can explore a range of proposals involving tax incentives and disincentives in general as well as specific issues such as the affordability to the unemployed of continuing to purchase insurance coverage from their previous employers, as authorized by COBRA.

And beyond the committee's jurisdiction, members can use their expertise in health care to call the nation's attention to the need for more comprehensive reform to benefit the health care of children. Indeed, it is precisely the experience of the committee in assessing the feasibility of mandated minimum health benefits that will position members to be especially effective spokepeople on children's overall health care coverage needs.

NACHRI's Recommendations for Specific Changes to Consider in Evaluating H.R. 4951

NACHRI strongly commends Rep. Stark for his introduction of a bill that includes several provisions, which reflect the health care coverage needs of children, particularly those of lower income working families:

- mandated maternity and infant care without deductibles, copayments, or pre-existing condition requirements;
- mandated dependent coverage, including children up to age 18 as well as chronically ill older children, without pre-existing conditions;
- mandated catastrophic coverage, which caps a family's annual medical expenses at $1,500; and
- advance payment of the health plan premium tax credit to qualified low income families.

We also would like to recommend consideration of the following additional provisions whose incorporation into the bill might further strengthen its coverage of children:

- In addition to consulting with the American College of Obstetricians and Gynecologists, the Secretary of DHHS also should consult with the American Academy of Pediatrics on the definition of infant care benefits.
- The bill provides for a 30 day election period before employer-paid coverage becomes effective. Given the critical importance of prenatal care at all stages of pregnancy, coverage of maternity care, delivery, and infant care should be effective on date of employment.
- The bill does not mention any life-time maximum on coverage. According to the 1987 Hay/Higgins Benefits Report on health care plans of medium and large size employers, 44% of surveyed plans have life time maximums of $1 million or more. Twenty-six present of plans have no maximum. Therefore, we would recommend

establishing a life-time maximum of at least $1 million.

NACHRI appreciates very much having the opportunity to contribute to the subcommittee's consideration of minimum health benefits legislation. We would be happy to be of assistance to your continued deliberations.

STATEMENT OF
THE NATIONAL ASSOCIATION OF HOME BUILDERS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE COMMITTEE ON WAYS AND MEANS

SEPTEMBER 22, 1988

Mr. Chairman, on behalf of the more than 155,000 members of the National Association of Home Builders (NAHB), we respectfully submit this statement for the hearing record with regard to H.R.4951, the Employee Health Benefit Improvement Act.

NAHB's member firms are located in every state, the District of Columbia and Puerto Rico. They employ over 8 million persons and can be found in every type of community across the nation, representing rural and urban interests. The cohesiveness of the organization is maintained through a network of 780 local and 43 state affiliated associations.

While the association was founded to represent the small home builder, it has expanded through the years to include the diversified builder. Currently the average builder member participates in 2 or more different types of building activities, which include remodeling, commercial and industrial building, and single and multifamily housing.

HOUSING AND THE ECONOMY

Housing is one of the key indicators of the health and vitality of the nation's economy and the industry itself is one of the largest contributors to the country's economic system.

In 1987 alone, the value of all new housing totaled $139.6 billion, resulting in an estimated 2.4 million man years of direct employment. Those housing starts, numbering 1.617 million, represent a tax contribution to local governments of $1.5 billion. During the same period, housing and housing related industries contributed approximately $228.5 billion to America's economy -- which translates to about 5% of the gross national product (GNP).

The housing industry also plays an important role in the economic stability of many other industries, including real estate, architecture, banking institutions, housing manufacturers and the myriad of housing supply industries. For this reason, the ripple effect of the housing industry on the nation's economy is substantial.

MANDATED BENEFITS

NAHB opposes the concept of mandated benefits as proposed in H.R.4951. This legislation would require all employers to provide health insurance for their employees, including those working part time at a minimum of 17.5 hours a week, as a condition for doing business. Many of our builders, who run small business operations, cannot provide health insurance coverage to all their workers because they cannot afford it and remain competitive.

Imposing the requirements of H.R.4951 on the construction industry would be impractical due to the nature of its seasonal and intermittent workforce. The typical construction worker changes employers with much greater frequency than workers in most industries. Consequently, builders would be faced with an inordinate amount of recordkeeping requirements and increased costs from complying with this legislation. Additionally, the high costs of health insurance would leave employers with the option of reducing their workforce or increasing the price of their homes.

Forcing construction employers to extend health benefit coverage for all their workers employed at least 17.5 hours per week would create an adminstrative nightmare. Builders often hire workers for 20 hours one week, 15 hours the next, and then let the workers off for an extended period due to bad weather conditions or the cyclical nature of the industry. Therefore, builders would often be faced with having to provide benefits to their part-time help on an intermittent basis. This could force them to reduce their part-time help.

NAHB not only objects to this intrusion of government into the marketplace from both the policy and practical prospectives, we also protest the manner of its proposed implementation. Imposing a tax on non-compliance opens a potential "Pandora's box" of fines, penalties and litigation. Further, it creates a burden on the employer who would be charged with the responsibility of monitoring employees for their eligibility and restructuring, possibly on a regular basis, his payroll structure to account for advance payment of the proposed tax credit.

CONCLUSION

Congress should examine the impact that any proposal imposing a federal mandate would have on businesses. While no one will dispute the fact that there is a lack of adequate health care coverage for many low income people, the skyrocketing costs of health benefits insurance, as well as of medical treatment, are just as critical an issue.

Smaller firms would like to be able to provide health benefit coverage for all their workers; however, it is just not economically feasible for them to do so and remain competitive. It is even harder to conceive of how Congress expects these smaller firms to afford the costs through a mandate. Many small employers will have to scale back their operations, lay-off workers, or go out of business altogether.

The problem inherent with a federal mandate, as in H.R.4951, is that it cannot possibly take into account the myriad of circumstances that individual businesses face. A comprehensive federal mandate imposing health benefit coverage is as irrational as a federal law prohibiting it. Either would affect businesses in an adverse way. That is the reason why we currently have a voluntary benefits system in place. Decisions as to whether to provide health insurance and to whom belong in the private negotiation process. Furthermore, such a decision is made by each individual firm in accordance with employee needs, insurance availability, premium costs and the firm's ability to provide the coverage.

There is one provision in H.R.4951 that provides a positive step towards resolving the problem of the uninsured worker. That provision would raise the allowable income tax deduction for the health insurance costs of the self-employed to 100 percent from the current 25 percent.

Mr. Chairman, we applaud the subcommittee for holding this hearing. We would like to work with you to develop legislation that will address the concerns of employers in the construction industry and resolve the problem of the uninsured.

STATEMENT OF THE NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC., AND THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

The National Association of Social Workers (NASW) and the National Federation of Societies for Clinical Social Work (NFSCSW) are very pleased to present their joint views regarding H.R. 4951, the Employee Health Benefit Improvement Act of 1988. NFSCSW is a The National Association of Social Workers (NASW) and the National Federation of Societies for Clinical Social Work (NFSCSW) are very pleased to present their joint views regarding H.R. 4951, the Employee Health Benefit Improvement Act of 1988. NFSCSW is a federation of state organizations whose members are all clinical social workers involved in health and mental health practice; NASW is a membership organization representing over 116,000 professional social workers.

The social work profession has an historical track record of providing high quality health and mental health care. Massachusetts General Hospital hired its first medical social worker at the turn of the century. Since that time, social workers have become involved in virtually every component of the nation's health care delivery system, performing such critical functions as health education and promotion, high-risk screening and assessment, case management, financial counseling, patient advocacy, family education, discharge planning, post-hospitalization care and follow-through. And, today, clinical social workers are the single largest body of professionals offering mental health services to individuals, groups and families through private practice, group practice settings, health maintenance organizations, hospitals, agencies, clinics and employee assistance programs.

As a profession, social workers also have a longstanding history of advocating on behalf of equity and access to health and mental health care. As you are well aware, access to care has become dependent upon the financing of care, and the number of Americans who can no longer finance needed care is growing at an alarming rate.

- Since 1978, over 1 million individuals each year have been added to the growing number of the nation's uninsured.
- Today, an estimated 37 million Americans have no health insurance of any kind. An additional 50 million Americans are covered by health insurance plans which are considered inadequate and create serious problems of access to care.[1]

Access to health and mental health care has reached a state of crisis. The crisis affects both those families who have traditionally relied upon private health insurance plans to finance care, as well as families dependent upon a publicly financed system of care.

- 75% of the uninsured are American workers and their families -- representing 1/3 of the U.S. labor force.[2]
- Medicaid coverage of individuals with incomes below the poverty level has decreased as well. In 1975, 63% of individuals living in households below the poverty level received Medicaid coverage; by 1985, the figure had dropped 46% and is now estimated to be 38%.[3]

The inability to finance care, and the consequent lack of access to care, can affect all families. However, as may be expected, the problem is most dramatically evidenced within some of the nation's most vulnerable populations, raising serious questions of equity within the system.

- 32% of today's uninsured are children below the age of 18.

- 25% of the uninsured are Blacks, and 21% represent other minority groups.[4]

NFSCSW and NASW commend the Chairman for his leadership in introducing H.R. 4951, a bill which would extend access to basic health care to 23 million Americans -- a majority of the nation's uninsured population. The bill would also expand access to care for those workers who are currently underinsured against the costs of basic health care.

As representatives of mental health care providers, however, we are very concerned with the mental health benefit included in H.R. 4951. For years our nation's discriminatory attitude toward mental illness has been mirrored in distinctions in insurance coverage between physical and mental health treatment, as if it were less essential to treat mental illness. Yet, our progressive understanding of health has increased society's awareness that physical and mental health are inextricably connected. Studies have consistently shown that many patients who go to physicians' offices with physical complaints have emotional and psychological symptoms.

Our basic concerns with H.R. 4951's mental health benefit lie in two areas:

1. Outpatient Mental Health Benefit: The outpatient mental health benefit is modeled after the Medicare, Part B, benefit which is capped at a dollar limitation as opposed to a number of visits. The Medicare, Part B, mental health outpatient benefit was increased in 1987 for the first time since its inception in the program. And during the many years in between, the benefit's value eroded to such a degree that the benefit became severely inadequate. We hope that this may be avoided in H.R. 4951 by basing the benefit upon a reasonable number of outpatient visits, as opposed to a dollar cap.

2. Consumer Freedom of Choice/Access to Care: Medicare reimbursement for covered outpatient mental health services has traditionally been restricted to physicians -- a policy which we believe has negatively affected access to care and the cost of care. We believe that H.R. 4951 should not contain a limitation on the use of qualified mental health care providers. On the contrary, NFSCSW and NASW believe that H.R. 4951 should affirmatively offer consumers the freedom of choice to select among duly licensed mental health providers who are working within the scope of their practice as permitted by state law.

The inadequacy of the mental health benefit in H.R. 4951, coupled with the bill's pre-emption of state laws which regulate the content of health insurance, pose serious problems for consumers and the mental health care delivery system. H.R. 4951 would pre-empt all state laws which currently mandate mental health benefits and would also pre-empt existing state laws which guarantee consumers the freedom of choice to select a mental health care provider from a range of qualified mental health care professionals.

We strongly urge the subcommittee to remedy these problems by:

- Including an adequate mental health benefit in H.R. 4951; and
- Guaranteeing beneficiaries the freedom of choice through H.R. 4951 to select among qualified mental health providers -- including clinical social workers -- to obtain the covered mental health services.

THE MENTAL HEALTH BENEFIT

An increasing number of studies demonstrate the cost-effectiveness of making mental health care coverage available, and the key role of mental health care in offsetting the use and cost of unnecessary medical care.

For example, the President's Commission on Mental Health in 1978 concluded that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery. "As a group, this research is most striking," the Commission reported. "Research from health maintenance organizations (HMOs), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs."[5]

The Commission also determined that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than diagnosable physical illness.[6] A similar finding was reported by the Department of Health and Human Services in its 1984 study report titled, "The Hidden Mental Health Network."[7]

An article published by the Alcohol, Drug Abuse and Mental Health Administration summarized the results of twelve separate studies which have demonstrated that the cost of providing expanded mental health services was offset by a significant decline in medical utilization.[8]

Yet another study relating to the offset effect of mental health treatment on medical costs is a 1983 study on outpatient mental health treatment following the onset of a chronic disease. The findings indicate that outpatient psychotherapy beginning within one year of the diagnosis of one of four chronic diseases is associated with reduced charges for medical services by the third year following the diagnosis.[9] The authors conclude that the study "adds weight to the conclusion drawn from the reviews of the scientific literature that the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it."[10]

NFSCSW and NASW consider the inclusion of a mental health benefit as essential to H.R. 4951. We also wish to emphasize a few additional considerations for the design of a meaningful mental health benefit.

1. NFSCSW and NASW place a very high value on the provision of outpatient mental health care which often represents the least costly and least restrictive setting appropriate to the patient. Careful consideration must be given to the development of an adequate outpatient mental health benefit level to prevent inappropriate utilization of an inpatient benefit. And, consideration should be given to the use of peer review and case management mechanisms to extend the use of appropriate outpatient care should the outpatient benefit be exhausted.

2. The treatment of "medical management" visits as equivalent to any outpatient physician visit would appear reasonable in the context of the mental health benefit, as long as medical management is clearly defined and is exclusive of psychotherapy. However, given the historical and non-essential role of physicians as "gate-keepers" to mental health care, we believe that safeguards must be built into the concept of medical management in order to prevent any financial incentives to reinforce the gate-keeper approach to mental health care which could restrict access either to needed care or to care that can appropriately be provided by non-physician providers.

3. Coverage of treatment for alcoholism and drug abuse is essential to the mandated benefit and should be recognized as appropriate coverage together with the mental health benefit.

CONSUMER FREEDOM OF CHOICE WITHIN MENTAL HEALTH CARE

There are several compelling reasons why it is critical to include in H.R. 4951 a freedom of choice provision for mental health care (including both diagnosis and treatment) which recognizes clinical social workers and all other qualified mental health professionals, clinics and agencies as reimbursable providers of covered services. First, freedom of choice alleviates the problem of insufficient access to mental health care, particularly among underserved populations. Second, expansion of the pool of qualified mental health providers encourages healthy competition, enhancing cost-containment. And finally, as previously addressed, increased utilization of mental health treatment has been shown to result in decreased utilization of more costly medical and hospital services.

The ability of a consumer to select from a range of qualified mental health care providers for reimbursable care can determine access to mental health care -- particularly in rural areas. The National Center for Social Policy and Practice's Preliminary Report of the Geographic Distribution of Mental Health Providers demonstrates this point. In its pilot study of the relative distribution of social workers, psychologists and psychiatrists in six states with large rural areas -- Illinois, Oklahoma, Michigan and Texas, Florida and West Virginia -- the Center found that:

- Social workers are the only licensed mental health providers in approximately 1/3 of the counties in five of the six states studied; and

- The counties in which social workers were the only available licensed mental health providers were more rural and poorer than neighboring counties, with average per capita incomes approximately 25% below the states' average per capita income.[11]

Inadequate access to mental health services and to trained mental health professionals led the President's Commission on Mental Health in 1978 to recommend that Medicare and other publicly financed mental health service programs should provide direct reimbursement to all independent qualified mental health professionals who meet the requisite standards of education, experience and professional licensure/certification.[12] The fundamental point made by the Commission was that federal financing mechanisms should be based upon the appropriateness of care, not the discipline of the provider.[13]

Insufficient access to mental health services is not the sole justification for urging consumer freedom of choice in selecting among qualified providers. Several years ago, a well-known health care consulting firm published the results of a study prepared for the Federal Trade Commission on competition among health care practitioners, which examined the influence of the medical profession on the health manpower market. The study concluded that one of the principal ways to broaden consumer choice, and to diminish the monopoly power of physicians, was to allow consumers the freedom to select among a variety of health professionals. "If carefully designed, a system based on broadened choice could preserve professional competency while increasing competition among providers on the basis of the service they provide, quality and price.[14] The study warned that "unreasonable resistance to change in present manpower arrangements has, in some cases, prevented appropriate utilization of health resources and possibly raised the cost of care."[15] Lastly, some opponents of freedom of choice have argued that expanding the available provider base will cause a significant increase in utilization, and additional cost. Even if utilization were to increase with the inclusion of clinical social workers and other qualified mental health professionals in the provider pool, overall plan costs would not necessarily increase proportionately. To the contrary, as previously addressed, the evidence strongly suggests that increased utilization would be offset by corresponding cost savings.

Federally funded health insurance programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefits Program (FEHBP) have already recognized the importance of utilizing services of clinical social workers and other qualified non-physician mental health professionals. A 1986 study conducted by the Office of Personnel Management examined the effects of providing direct reimbursement to clinical social workers and other non-physician providers under FEHBP. OPM concluded there was no basis to anticipate adverse impact on cost or quality of care from mandating coverage of qualified non-physician providers, including clinical social workers.[16]

The CHAMPUS program reports a similar experience. In 1980 Congress directed CHAMPUS to conduct a demonstration project by including clinical social workers as independent providers of covered services for a two-year period, in order to assess the impact on cost and utilization. In 1982, following this experimental period, Congress authorized continuation of the independent provider status based on the finding from the demonstration project that "no quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach."[17]

H.R. 4951 is a very important step forward in extending health care to all working Americans. NFSCSW and NASW urge that the bill be modified to include a basic mental health benefit coupled with a provision which would protect the beneficiaries' freedom to choose from a range of qualified mental health providers.

We commend the Chairman for his leadership in this area, and appreciate the opportunity to express our views to the Committee on this important issue.

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NATIONAL CENTER FOR SOCIAL POLICY & PRACTICE

PRELIMINARY

REPORT OF THE GEOGRAPHIC DISTRIBUTION OF MENTAL HEALTH PROVIDERS

(A PILOT STUDY)

Commissioned by the Department of Legislative Affairs
National Association of Social Workers

JULY 1988

7981 Eastern Avenue • Silver Spring, Maryland 20910 • 301-565-0333

REPORT OF THE GEOGRAPHIC DISTRIBUTION OF MENTAL HEALTH PROVIDERS

(Pilot Study)

Understanding a community's access to mental health care requires the enumeration of manpower available to provide these services. In addition, it requires a descriptive geographic distribution of the mental health care providers by type and level of training. Mental health service providers for purposes of this discussion are psychiatrists, psychologists and social workers, although it is recognized that other providers may also offer various services.

Knowledge about the issues surrounding the maldistribution of mental health professionals in this country is not uniformly apparent among the nation's legislators and policymakers. The extent of the shortages of certain providers in underserved communities is often lost in the national and statewide aggregated counts and projections of health manpower. As national and state legislation is developed, there is a danger that people residing in the less populated rural and poorer areas of this country will be unable to obtain access to mental health care providers because of de-facto exclusionary policies which deny direct reimbursement (Medicaid and Medicare) for social workers who are the principle providers of mental health services in many of those areas.

Policymakers, at the national and state levels, are presently considering or developing laws and regulations to improve access to mental health services, particularly at the community level. Financing alternatives and authorization of direct reimbursement for various providers under Medicare and Medicaid are being debated. Accordingly, it is imperative that policymakers recognize the important role of social workers in the delivery of mental health services to areas that otherwise would be underserved. In order to continue to make these services available, it is essential that social workers be included in the financing and reimbursement packages under consideration.

Studies of the future of the American health and mental health systems and the relationships among the mental health disciplines would be incomplete without consideration of the contribution made by nonpsychiatric providers. Many people who visit health care providers are without evidence of organic pathology but are suffering from psychological or maladjustment factors. Because of declining psychiatrist-to-population ratios, psychiatrists will tend to treat only the "sicker" patients and psychologists and social workers will assume more responsibilities for triage and treatment of other patients in need of mental health services.

Since there are approximately 300,000 social workers in this country and fewer than 30,000 psychiatrists and 45,000 licensed psychologists, it may be postulated that more social workers are serving the less populated rural and poorer areas of this country than the other two types of mental health providers. People residing in rural areas, particularly the poor, are more likely to use whichever mental health professional is geographically closer rather than a provider who is located at a great distance.

Knesper, et al (1984) found that, in 1980 there were strong relationships among the location patterns of the three types of mental health providers. The counties with high psychiatrists-to-population ratios were also likely to have high ratios of psychologists and social workers. One explanation for this phenomenon of similar distribution patterns for the three provider types was that they were attracted by the same environmental characteristics. Counties with higher incomes, higher educational attainment, more urbanization and with other health resources were more likely to attract all types of health providers.

In 1988, we face a new series of questions based on the health care system's movement toward a competitive model of delivery and the resulting changes in referral and reimbursement patterns. Specifically, the increased availability of direct public and private insurance reimbursements for psychologists and social workers, along with the declining numbers of psychiatrists (Jenkins and Turk, 1983), will change the distribution patterns of psychologists and social workers.

The National Center for Social Policy & Practice undertook a pilot project to test the feasibility of collecting information on the geographic distribution of psychiatrists, psychologists and social workers by county in six states. The states selected for this pilot project were: Michigan, Illinois, Oklahoma, Texas, Florida and West Virginia.

The purpose of this project was to test the feasibility of developing a county-by-county geographic distribution count (numerical and provider/population ratio) of psychiatrists, psychologists and social workers providing direct services in selected states. This information will demonstrate to national and state policymakers that in order to make mental health services geographically and financially accessible to the rural and disadvantaged populations of this country, direct reimbursement for the services of social workers needs to be authorized through all proposed mental health payment plans.

METHODOLOGY

Six states were selected on the basis of regional distribution, rural-urban mix, and varying licensure laws.

The latest available enumeration and distribution of psychiatrists by county was obtained from the Health Services and Resources Administration's Area Resource File. This was the 1983 data from the American Medical Association. The enumeration of psychiatrists counted board-eligible and board-certified specialists and treated each psychiatric resident as one-half of a psychiatrist equivalent.

For social workers and psychologists, actual 1988 lists of state licensed practitioners were solicited and received from the state licensing boards of the respective states. As anticipated, the diversity of state definitions and licensing law requirements for both psychologists and social workers necessitated state-by-state interpretation. Where multilevel licensing was utilized, only the higher levels were considered for inclusion. Specifically, psychologists were only considered with Ph.D. degrees except in West Virginia which licenses psychologists with a masters degree. Social workers were only counted if the level of license required a minimal attainment of the MSW. Florida has a restrictive licensing law and only social workers in private practice tend to be licensed. Those social workers in public agencies do not usually obtain licenses and therefore social workers are undercounted compared to actual MSW providers. For a true delineation of mental health providers, some states may require the use of other sources of data.

The U.S. Bureau of the Census' estimates of the 1986 population of counties was used to calculate the provider to population ratios for psychologists and social workers. The actual 1983 county populations were used to calculate the ratios of psychiatrists per population ratios.

The 1987 per capita incomes for the states and counties was based on estimates from the U.S. Bureau of the Census.

FINDINGS

In five of the six states studied to date, social workers outnumber the other two types of mental health providers. The provider per 100,000 population ratios for the states are presented in Table 1. The preponderance of social workers in all of the states is consistent with the exception of Florida.

TABLE 1
PROVIDER TYPE PER 100,000 STATE POPULATION

STATES	PSYCHIATRISTS	PSYCHOLOGISTS	SOCIAL WORKERS
Illinois	9.5	19.4	53.1
Michigan	10.1	14.7	92.0
Oklahoma	5.5	10.5	23.1
Texas	8.5	13.7	32.6
Florida	8.5	17.3	16.6*
W. Virginia	5.5	13.9**	43.6

* Florida license requirements are restrictive and required only for private practice.

** W. Virginia licenses masters and M.S. and Ph.D. psychologists

The number of counties in the selected states without any mental health providers (psychiatrist, psychologist, or social worker) was determined and the results are provided in Table 2 below. The data was then examined to determine which counties are without psychiatrists or psychologists, but are served by social workers. These counties are identified in blue on the state maps at the end of this report.

TABLE 2

UNDERSERVED COUNTIES IN SELECTED STATES

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STATES	TOTAL COUNTIES	COUNTIES WITH NO PROVIDERS		COUNTIES SERVED ONLY BY SOCIAL WORKERS	
	No.	No.	%	No.	%
Illinois	102	13	12.7%	34	33.3%
Michigan	83	1	1.2%	23	28.0%
Oklahoma	77	23	29.9%	26	33.8%
Texas	254	101	39.8%	65	25.6%
Florida	67	11	16.4%	3	4.5%
W. Virginia	55	2	3.6%	14	25.5%

As Table 2 illustrates, licensed social workers represent the only category of mental health care providers in approximately one-fourth of the counties in the states studied. There is broad geographic diffusion of social workers and as expected, the counties served only by social workers are rural and have lower per capita incomes than the state as a whole. This is demonstrated in Table 3 where the counties served only by social workers have per capita incomes approximately 25 percent below the state-wide average per capita income.

TABLE 3

COUNTY PER CAPITA INCOME AND PROVIDER DISTRIBUTION

1987 (est.) MEDIAN PER-CAPITA INCOME

STATE	State Median	Counties Served Only By Social Workers			Percent Below State Median
		No.	%	Per cap.	
Illinois	$12,575	34	33.3%	$10,347	17.7%
Michigan	$10,584	23	28.0%	$7,872	25.6%
Oklahoma	$11,462	26	33.8%	$8,194	28.5%
Texas	$11,787	65	25.6%	$9,060	23.1%
Florida	$12,558	3	4.5%	$8,397	33.1%
W. Virginia	$8,434	14	25.5%	$6,686	20.7%

Table 4 is a summary of the distribution of providers which shows a clustering of the psychiatrists, psychologists and social workers in the majority of the counties. This geographic clustering occurs primarily in the urban counties, and the provider-per-population ratios for all three mental health providers are high. The study findings also demonstrated that the counties with no providers were usually contiguous with counties served only by social workers; this is visually shown on the colored maps on pages 12 to 17.

TABLE 4

PERCENT OF COUNTIES SERVED BY TYPES OF PROVIDERS

State	Psychiatrist, Psychologist & Social Worker	Psychologist & Social Worker Only	Social Worker Only	None	Other*
Illinois	29.4%	18.6%	33.3%	12.7%	5.9%
Michigan	42.7%	26.8%	28.0%	1.2%	1.2%
Oklahoma	18.2%	14.3%	33.8%	29.9%	3.8%
Texas	19.0%	10.2%	25.6%	39.8%	2.7%
Florida	52.2%	9.0%	4.5%	16.4%	17.9%
W.Virginia	36.7%	34.5%	25.5%	3.6%	5.5%

* Primarily psychiatrist and social worker

DATA LIMITATIONS

Measures of provider distribution depend on available information. Records of licensed providers are compiled by "place of residence" rather than actual employment site. The data does not allow a determination of active employment in the profession. Some of the licensed providers may be retired or otherwise not employed in the mental health field and their status is unable to be determined from license lists. This problem will be the same for all three provider types.

SUMMARY AND CONCLUSION

Mental disorders are common throughout the United States, in rural areas as well as in cities. Equal access to mental health services for people residing in rural counties necessitates the geographic presence of providers. Psychiatrists tend to set up practice in the larger urban areas where the educational and professional institutional affiliations are available. The psychologists and social worker per population ratios are also higher in the urban areas for similar reasons. Social workers are, however more geographically dispersed and more likely to reside in rural counties than other mental health providers. Therefore, they are the primary providers of mental health services in many of the rural and lesser affluent counties of this country.

A future study should be undertaken to review the clinical tasks performed by social workers who reside in those rural counties and to define the scope of mental health services which they provide.

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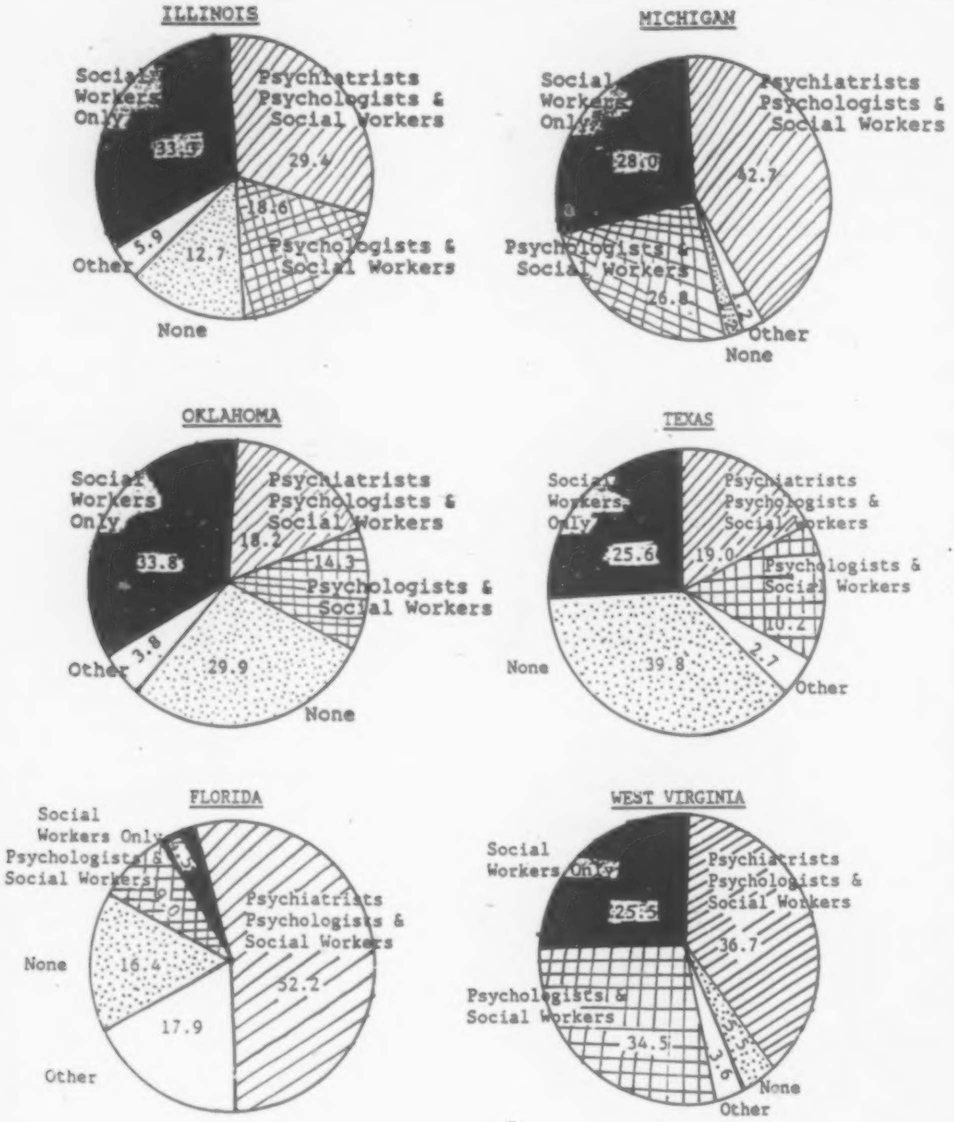
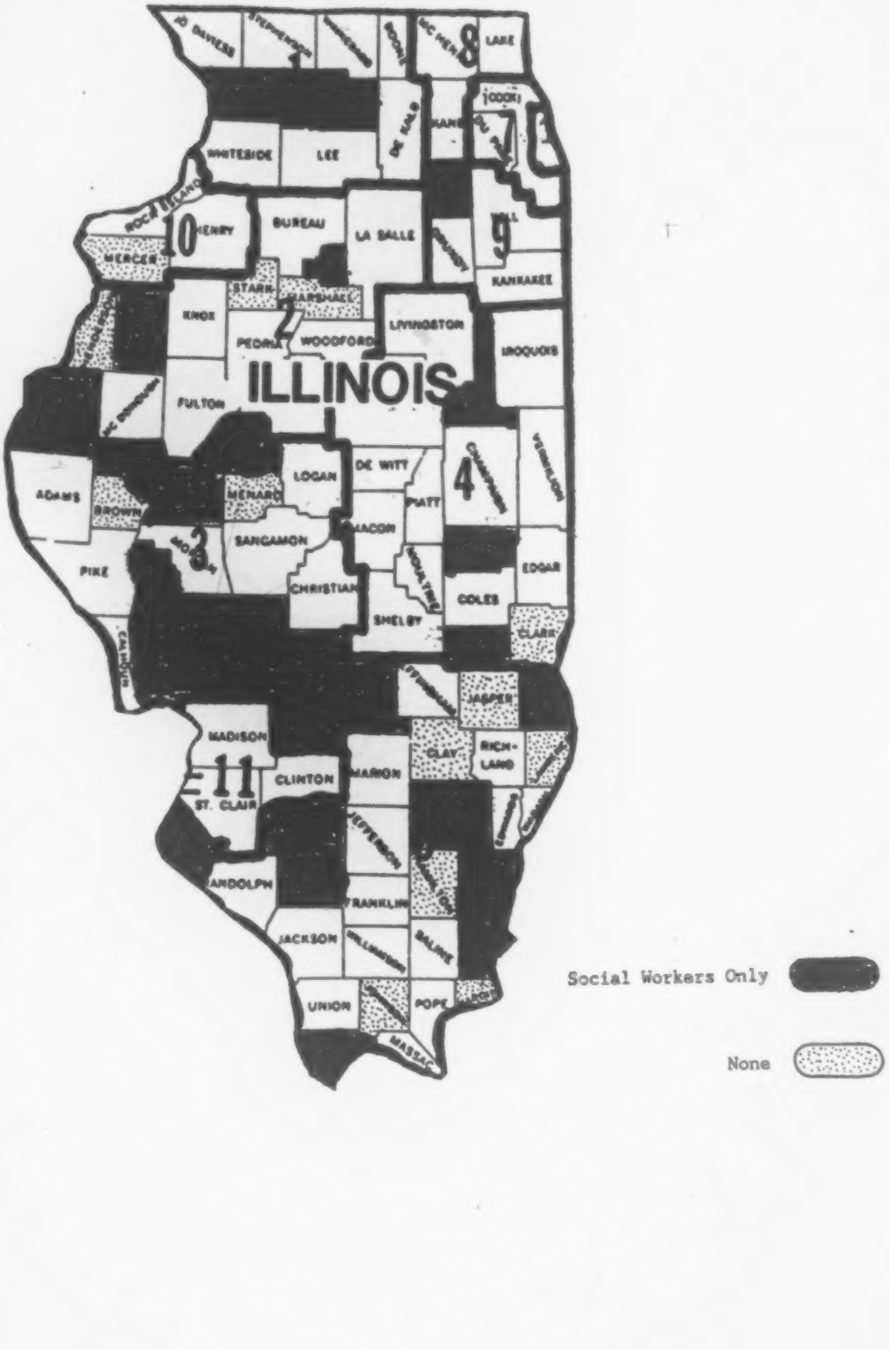
PERCENT OF COUNTIES SERVED BY

PROVIDER TYPE

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HENRY
BUREAU
LA SALLE
WILL
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KANKAKEE
GRUNDY
MERCER
STARK
MARSHALL
KNOX
PEORIA
WOODFORD
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LIVINGSTON
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LOGAN
DE WITT
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VERMILION
ADAMS
BROWN
MENARD
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EDGAR
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SHELBY
CLARK
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JEFFERSON
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POPE
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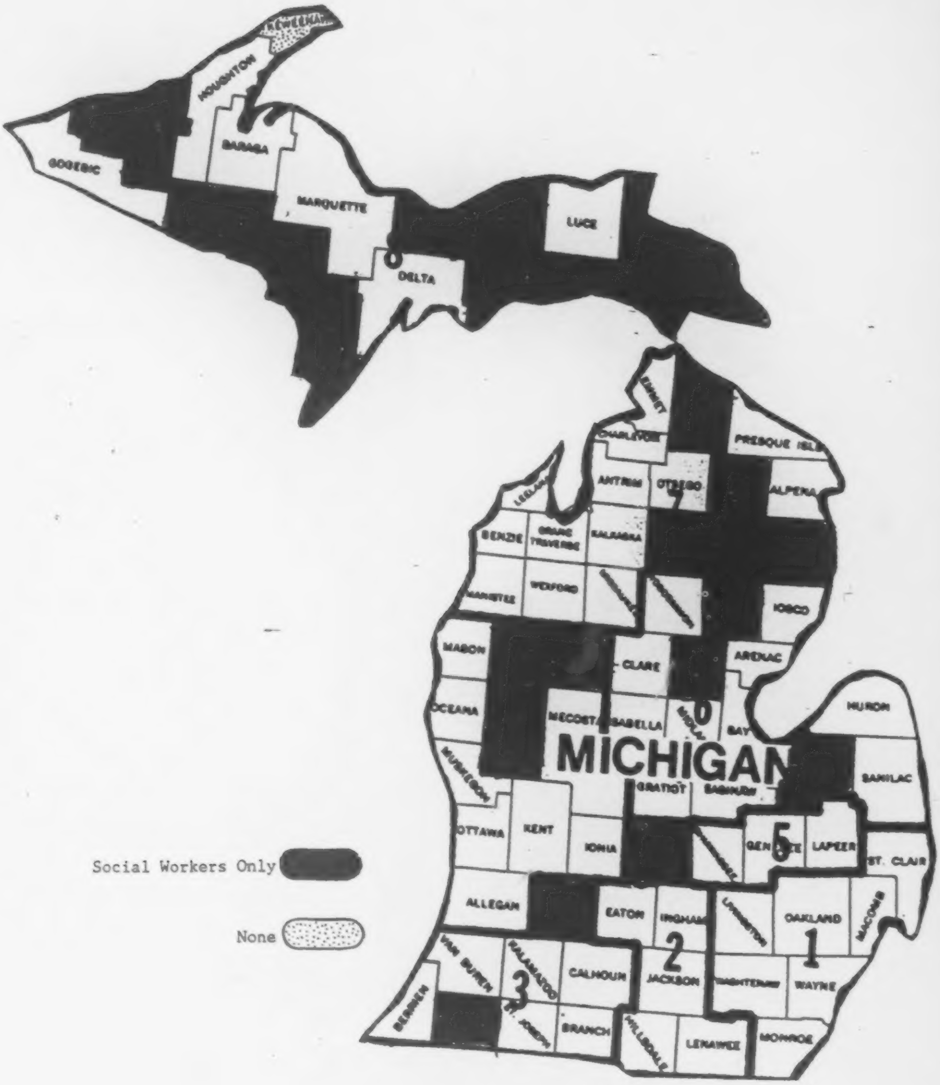
Social Workers Only
None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Social Workers Only
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EATON
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LIVINGSTON
OAKLAND
MACOMB
None
VAN BUREN
KALAMAZOO
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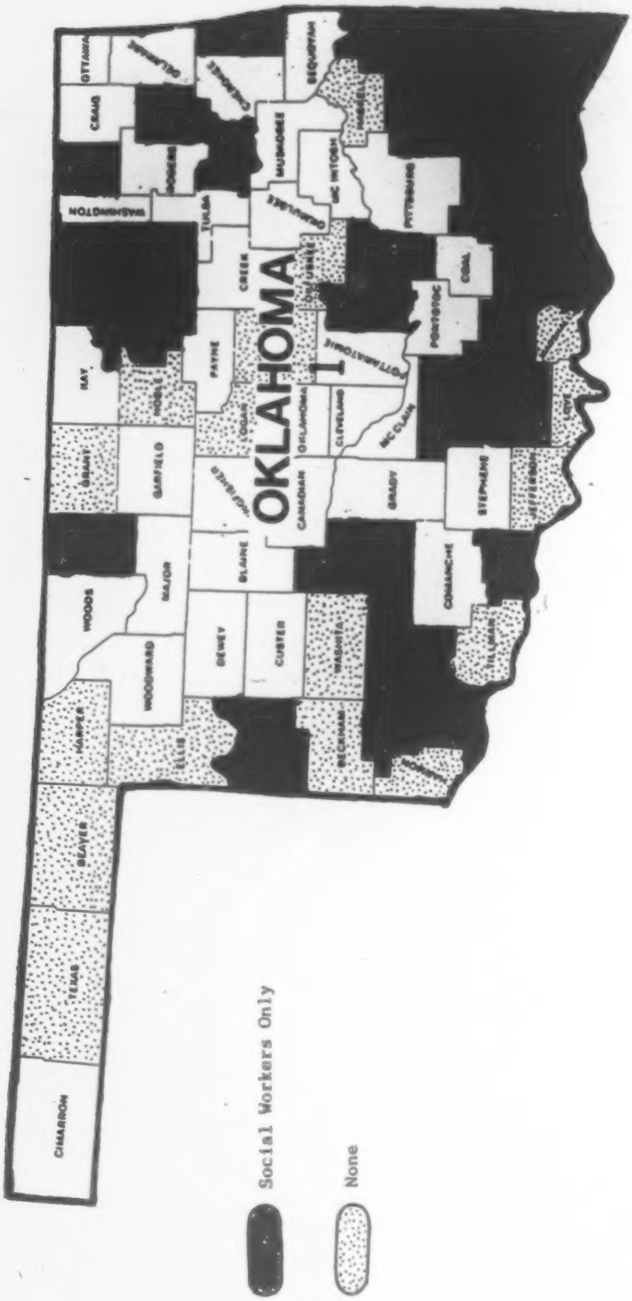
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WOODWARD
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Social Workers Only
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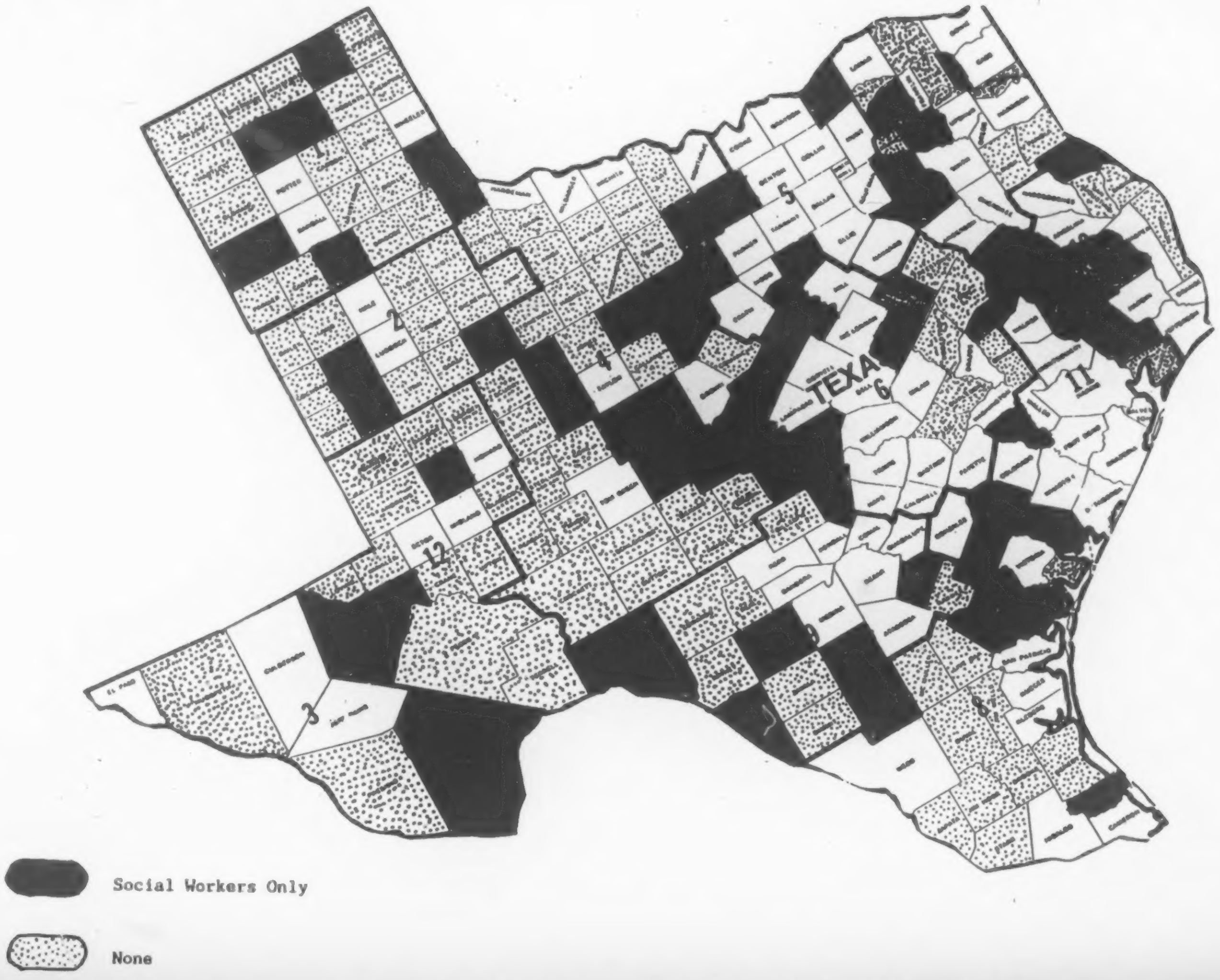
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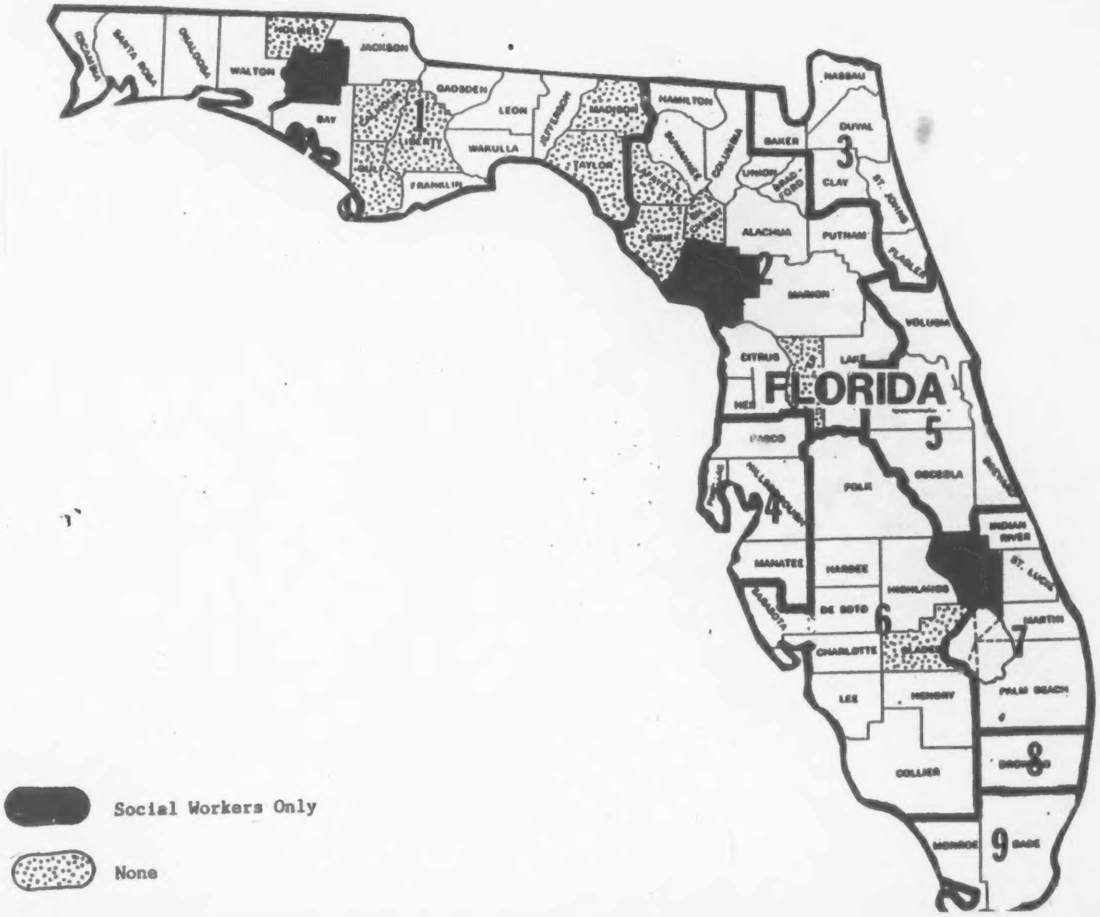
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FLORIDA
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PASCO
PINELLAS
HILLSBOROUGH
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POLK
OSCEOLA
BREVARD
INDIAN RIVER
ST. LUCIE
MANATEE
HARDEE
HIGHLANDS
SARASOTA
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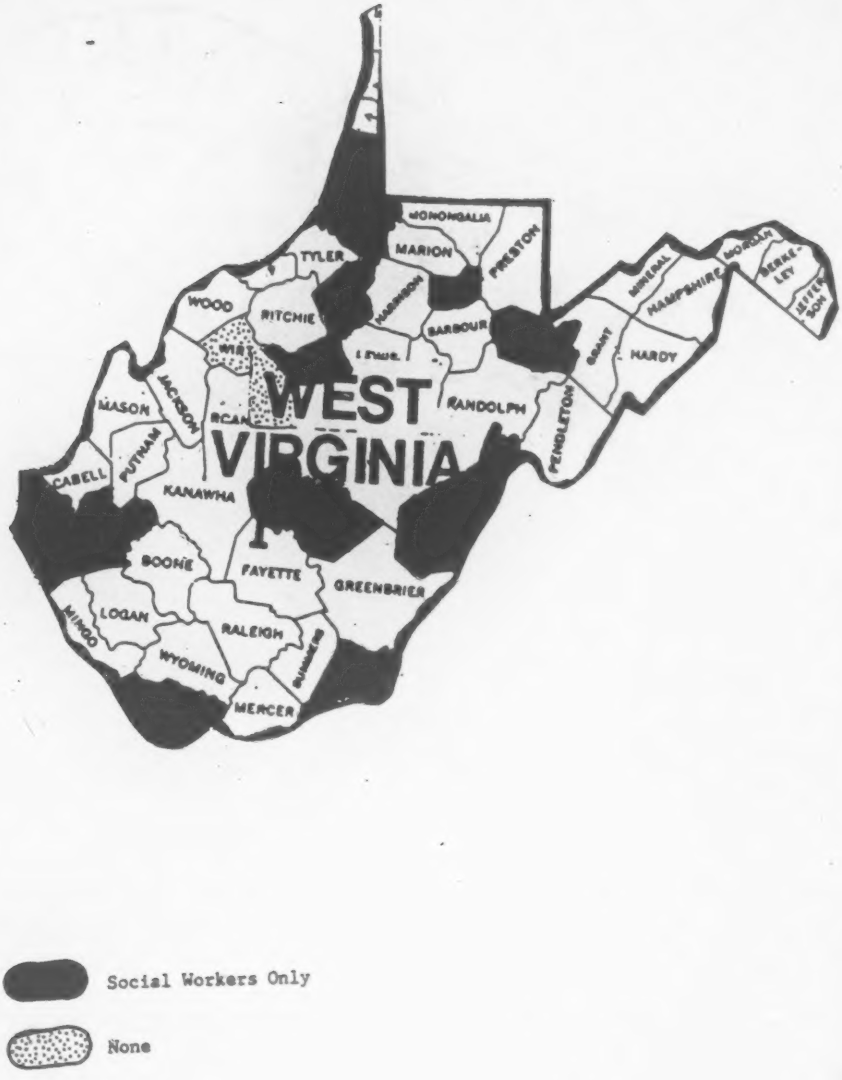
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RANDOLPH
PENDLETON
GRANT
MINERAL
HAMPSHIRE
HARDY
MORGAN
BERKE-LEY
JEFFER-SON
BOONE
FAYETTE
GREENBRIER
MINGO
LOGAN
RALEIGH
WYOMING
SUMMERS
MERCER
Social Workers Only
None

NRC National Rehabilitation Caucus

A national focus for the advancement of rehabilitation . . ., through advocacy, education, research and communications

Steven C. White, Ph.D.
Chairperson
Kenneth D. Davis, P.T.
Vice-Chairperson
Mary G. Swope
Secretary/Treasurer

September 28, 1988

The Honorable Fortney H. Stark
Chairman, Subcommittee on Health
House Ways and Means Committee
1114 LHOB
Washington, D.C. 20515

Re: Comments on H.R. 4951

Dear Representative Stark:

The undersigned organizations, participants in the National Rehabilitation Caucus (NRC), have followed your discussions of minimum health care coverage for workers with great interest. We appreciate your ongoing leadership of programs that improve the health and quality of life of people with disabilities. In view of this support, we would like to inform you that NRC participants are actively discussing the concept of minimum health benefits and wish to contribute to your work on this issue. We share a common concern for the often overlooked role of rehabilitation services in this nation's public and private health insurance plans.

As you may know, the NRC represents a broad spectrum of rehabilitation service providers, professionals and related interests. The NRC believes that access to rehabilitation services in acute, home and community-based settings is critical to a minimum health benefit plan for American workers.

On August 12, 1988, several NRC participants met with House Ways and Means Committee professional staff analyst, David Abernathy, to discuss H.R. 4951, the Employee Health Benefits Improvement Act of 1988. During that meeting, Mr. Abernathy invited the NRC to submit comments on H.R. 4951, which currently would include coverage for inpatient and outpatient rehabilitation services, as does the Medicare program.

Our comments emphasize the prevalence of existing coverage for such services, as well as their cost effectiveness and overall importance to quality health care. Kindly include the text of this letter in the record for the hearings concerning H.R. 4951 held on September 22, 1988.

10801 Rockville Pike • Rockville, Maryland 20852 • (301) 897-5700

- **The Scope of Rehabilitation Services**

Rehabilitation services and programs promote the restoration of functional abilities of individuals with physical, communicative, cognitive, and sensory-perceptual impairments. Rehabilitation includes a broad range of services, including physical therapy, speech-language pathology, occupational therapy, audiology, rehabilitation nursing, assistive device technology, homemaker-home health aides, and physician services.

Rehabilitation occurs in a variety of settings, such as hospitals (free standing and distinct rehabilitation units), rehabilitation agencies, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and private offices and homes. The extent to which medically necessary services are covered by health insurance sometimes involves arbitrary limitations on duration and frequency of service and caps on reimbursement.

Quality health care includes a broad spectrum of hospital, home and community-based rehabilitation services. Rehabilitation is tailored to the unique needs of the patient. Consequently, access to a range of services in a range of settings maximizes patients' opportunities to receive timely and appropriate care and maximizes individual function, independence, and ideally, return to work. For workers and their dependents with serious illness, injuries, and disabilities, limits on access to care translate into less than optimum recovery.

Early access to rehabilitation services frequently prevents the development of secondary problems, either physical, mental or behavioral, which can have an enduring and detrimental influence on an employee's recovery process. If rehabilitation is appropriately timed for critical periods in the recovery process, immediate and long-term treatment effects are going to be greater than if the same rehabilitation services are provided after those critical periods.

For these reasons, those individuals who would be covered under H.R. 4951 deserve the opportunity to receive services in the setting most appropriate to their personal and health needs. At a minimum, therefore, the rehabilitation services benefits should cover such care in the hospital, home and community settings.

- **Cost Effectiveness of Rehabilitation**

In terms of cost effectiveness, rehabilitation ranks favorably as an alterative to extended acute care. Research shows that the average costs for rehabilitation are two-thirds that of acute care. For example, early rehabilitation saves an average of $6,404 for each surviving stroke patient fortunate enough to receive it. In fact, cost studies of stroke rehabilitation show considerable return on the investment in services. A person who is not rehabilitated costs $92,736 in 1980 dollars more to support than a rehabilitated patient living at home. The average cost of rehabilitating an individual who has had a stroke is $8,000 to $11,500 in 1980 dollars. This results in average savings of $81,250 to $84,740, again in 1980 dollars.

A recently completed survey by the Health Insurance Associations of America concluded that for every dollar spent on rehabilitation, $11.00 is saved in other benefits that would have been paid to the affected individuals. Other studies have shown similar results:

- A 1981 Insurance Company of North America Study concluded that in long-term disability cases, for every dollar spent on rehabilitation, $17.00 is saved in other benefits that would have been paid to the beneficiary.
- In 1981, Natisco Rehabilitation Management, Inc., a case management company, estimated that for every dollar spent on rehabilitation, $12.68 was saved in claim costs.
- Several studies on spinal cord injuries concluded that for every dollar spent on rehabilitation, $3.00 to $6.00 is saved.

- **Coverage for Rehabilitation**

Coverage for rehabilitation services is widespread. Public and private health insurers customarily include some level of coverage for rehabilitation services in the benefits they offer. Coverage for rehabilitation services is delineated in terms of type of services, site of service delivery, scope of service and describes which services are covered, where services are covered, and how services are provided. In order to take full advantage of rehabilitation's cost effectiveness, coverage for these services must extend to a variety of settings.

A substantial share of employee health plans include coverage for rehabilitation services. For many employers, the impetus for including this coverage is based on the recognition that the relative costs of rehabilitation services are preferable to the high costs associated with long-term worker disability. In 1985-86, the Institute for Rehabilitation and Disability Management, a joint venture between the Washington Business Group on Health and the National Rehabilitation Hospital, conducted a national survey of 400 major employers. Some of the significant findings include the following:

- Sixty-five percent of the surveyed companies reimburse for rehabilitation services in community hospitals, while sixty-one percent reimburse for rehabilitation services in rehabilitation specialty hospitals.
- Seventy-two percent of the responding companies reimburse for outpatient rehabilitation services.
- Eighty-one percent reimburse for inpatient and outpatient physical therapy.
- Fifty-three percent of the responding companies reimburse for home-based rehabilitation services.

A minimum benefits package thus should include rehabilitation services provided in all settings, in hospitals and community-based settings alike, so as not to undercut benefits currently provided by most major employers. Rehabilitation services have been added to employer-paid health benefit plans at little or no cost.

In addition to the broad coverage extended to rehabilitation services in federal health programs, such as Medicare and Medicaid, there is a precedent for federally-mandated minimum health coverage that includes rehabilitation. Under the Federal Health Maintenance Organization (HMO) Act of 1973, guidelines specifically require that short-term rehabilitation services be available to enrollees, although varying HMO interpretations of this requirement remains a problem. The Group Health Association of America reports that 99% of HMO plans offer physical therapy benefits, 97% offer home health benefits, 91% offer benefits for communicative disorders that are delivered by speech-language pathologists, and 80% offer occupational therapy benefits.

- **Conclusion**

The NRC believes that a meaningful minimum health benefit must include access to a range of rehabilitation services in acute, home and community settings. Incorporation of coverage for rehabilitation services such as physical therapy, occupational therapy, speech-language pathology, audiology, rehabilitation nursing, homemaker-home health aide, and assistive devices in home and community-based settings in your minimum health benefits legislation will effectively provide access to such services for most of the workers you intend to assist.

In the absence of coverage for these services, many workers will simply forego needed rehabilitation care, thereby jeopardizing their health and risking more serious and costly health problems in the future. Ultimately, passage of a minimum health plan which adequately provides for rehabilitation services for workers is in the best interest of employers and employees alike, and will appropriately address the health needs of American workers and their families.

Section 2. (Mandated Employer Coverage of Health Care for Employees) of H.R. 4951 would amend Chapter 47 of the Internal Revenue Code of 1986 by adding a new Section 5000A.(e)(2)(A), requiring that employers' group health plans must provide for coverage of health care benefits not less in amount, duration, or scope than those provided under title XVIII of the Social Security Act...." Subsection (B) further requires that plan provide for rates of payment:

> "(i) for items and services described in such that the rates in the aggregate insure access to covered items and services and assure a level of quality of items and services equal to at least the level enjoyed by individuals entitled to benefits under title XVIII of the Social Security Act...."

The NRC believes that coverage of rehabilitation services at the level of the Medicare benefit, as provided in H.R. 4951, is an important first step in creating adequate health insurance for employed Americans and their dependents.

Thank you for your consideration of our concerns. Should you have any questions on these comments, please contact me.

Sincerely,

Steven C. White, Ph.D.
Chairperson

On behalf of:

American Academy of Physical Medicine and Rehabilitation
American Congress of Rehabilitation Medicine
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
National Association for Home Care
National Association of Rehabilitation Agencies
National Association of Rehabilitation Facilities
National Easter Seal Society
National Head Injury Foundation

cc: Members, Health Subcommittee
House Ways and Means Committee

STATEMENT OF THE NATIONAL RESTAURANT ASSOCIATION
on the EMPLOYEE HEALTH BENEFIT IMPROVEMENT ACT OF 1989, H.R. 4951
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH,
AUGUST 9, 1988

The National Restaurant Association appreciates this opportunity to present its views regarding the Employee Health Benefit Improvement Act, H.R. 4951. We are the leading trade association for the U.S. foodservice industry, representing tableservice restaurants, fast food outlets, cafeterias, and institutional feeders such as hospitals, universities and military clubs.

With over 600,000 establishments, the foodservice industry employs 8 million workers, or about 7% of the nation's work force. In 1989, the industry is expected to have sales in excess of $213 billion.

Our industry is aware that there are gaps in the existing private health insurance system, and we agree that in an ideal world universal access to health insurance is a worthy goal. But our members must operate in the real world, and we do not consider the broad-brush approach of H.R. 4951 to be a realistic solution to the problem of the uninsured. To force all American businesses to provide health care benefits, regardless of the cost and without thoroughly reviewing all of the consequences, will in the long run only hurt those this committee is trying to help.

Restaurants and other industries dominated by small businesses* would bear the heaviest burden if H.R. 4951 were enacted. With lower profits, less stability and greater employee turnover than their larger counterparts, small businesses would be least able to offer the benefit package required under the bill. And their employees, who generally receive lower wages and are more apt to work part-time, would also lose, since the high cost of compliance would leave many employers with no choice but to reduce the hours of their least productive employees.

The very characteristics that have made restaurants and other small businesses such a dynamic economic force and the source of millions of entry-level jobs also make them especially sensitive to the labor cost increases that a bill like H.R. 4951 would cause. The restaurant business is a very labor-intensive one. Our industry employs large numbers of young, inexperienced and part-time workers, many of whom would otherwise be without jobs. We employ more teenagers than any other industry, and we have the shortest average workweek (approximately 26 hours) of any industry.

Many of these employees are only marginally attached to the work force. They may be students with part-time jobs, mothers who work to bring extra income into the household, or retirees who wish to continue to be productive but don't want a full-time job. They are essential to our operations, but most of our members cannot afford to provide them with the array of benefits required under H.R. 4951. For small independent restaurateurs already faced with high payroll costs, the additional expense of providing comprehensive health benefits to all employees--without regard to their level of productivity--is simply prohibitive.

Any major increase in labor costs will be the straw that breaks the back of many of these firms. In studying the Kennedy-Waxman proposal, the Congressional Budget Office determined that businesses might decide either to pass on the higher benefit costs to consumers or absorb the costs by lowering their profit margins. For restaurants, these are not alternatives. Our industry is highly competitive, and there is a limit to the amount of increased labor costs we can pass on to our customers. Restaurants compete not only with each other, but also with the cost of food at grocery and convenience stores. In the restaurant industry, passing on costs can be the economic equivalent of suicide. And when many restaurants barely turn a profit in even the best of times, squeezing profit margins is not an option either. (See chart on page 4). For many, the only way to absorb labor cost increases is to eliminate jobs or curtail employee hours.

While the National Restaurant Association and its members adamantly oppose H.R. 4951, we do applaud the committee for its inclusion of a provision to permanently institute 100% deductibility of health insurance premiums for the self-employed. This represents a major step forward in the equitable treatment of sole proprietorships, partnerships and corporations.

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* Seventy percent of all foodservice operations have sales of less than $500,000 per year.

However, by including such a provision, with the attached mandate of requiring health care coverage, the committee assumes that all small businesses are making a sizeable enough profit to actually make a tax deduction a true advantage. In particular, new businesses, just starting out may not turn a profit for several years. By dramatically increasing the cost of carrying all employees, the viability of new firms will be threatened and those who are considering starting up new businesses will be discouraged.

Of course, many of our members do provide health care benefits to their employees. The National Restaurant Association conducted a survey among a random sample of 770 members in early 1988. Its purpose was to determine:

- availability of employer-provided health benefit coverage for industry employees

- enrollment in health insurance plans

- characteristics of health insurance plans

The results of our industry survey were very much in line with those of the rest of the business community. A study by the Bureau of Labor Statistics shows that by the time a company has 100 employees, it will have added health care coverage in almost all cases. As small firms grow and become more profitable, they add to their compensation plans, and health insurance is generally one of the first benefits they offer.

Our research reinforces this. We found that:

1. More than half of small companies with sales under $500,000 do not provide any health insurance for hourly or salaried employees.

2. As company sales size increases the likelihood of providing coverage for both hourly and salaried employees rises from 27% of businesses with sales under $500,000 to 90% of those with sales of $10 million or more.

3. Ninety-six percent of restaurant companies with sales of $1 million or more provide health insurance coverage for employees.

In sum, most companies that do not provide health care cannot afford to do so. The decision of whether or not a business should provide health care coverage or any other benefit for their employees is made after all of the economic ramifications for the company have been studied. Then and only then is a conscious decision made whether or not to provide the benefit. For the Congress to move ahead without considering all of the economic ramifications of this mandate on businesses would be wanton and reckless.

In addition to the problems premium costs would impose upon employers, the National Restaurant Association is opposed to several other provisions in H.R. 4951.

Tax Assistance to Low-Income Employees

Under H.R. 4951, low-income employees would be eligible for an income tax credit similar to the earned income credit that would be worth up to 50% of the premiums of the employer health plan. The credit would be paid to the employer at the end of the tax year after he has made regular payments to the employee. The employee would allegedly use the payments as part of his or her employee contribution for health care premiums. Employers, in effect, would be advancing the money to employees while awaiting reimbursement from the federal government. This represents an ongoing threat to a firm's cash flow.

This proposal would require the employer to certify and document qualified employees for federal reimbursement. The restaurateur would have to maintain the necessary paperwork and would be liable for any misrepresentations. This extremely complex process would add to the paperwork avalanche many small businesses are already coping with. For example, restaurateurs must currently comply with:

1. Tip reporting requirements
2. FICA taxes on employee tip income
3. COBRA continuation coverage
4. OSHA Hazard communication standard
5. INS Employment Eligibility Verification form

In January of 1989, our members and the rest of the business community will be faced with another paperwork nightmare--Section 89 nondiscrimination rules. We are still trying to understand how these complex regulations will affect our membership since they have not yet been published by the Internal Revenue Service.

Even experts in the employee benefits field have great difficulty complying with the above-mentioned regulations. Small business owners often do not have access to these experts and must deal with the paperwork quagmire on their own.

Paid COBRA Continuation Coverage

The National Restaurant Association opposes a provision of H.R. 4951 that would require employers to pay for continued group health care coverage for 60 days following an employee's involuntary termination.

Many employers are just now beginning to assess the impact of the little-noticed provision in the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) that requires employee paid continued coverage. As you know, Congress failed to grant the business community the opportunity to comment on this legislation before it was enacted. Comply as they must, restaurateurs are reeling from the paperwork requirements and potential premium increases this well-intentioned proposal brought about.

Since COBRA's enactment, the National Restaurant Association and others have been united and vocal in our opposition to COBRA. Expanding upon this ill-considered benefit by requiring employers to pay for the coverage is misguided and will place an even heavier burden on struggling companies.

State Risk Pools

We understand your desire to make health care coverage available to those who wish to purchase it. We do, however, adamantly oppose taxing employers to fund the shortfalls in mandated state risk pools. Since the risk pool premiums will be high, only the sick and those in dire need of medical attention will wish to buy into the pools. Shortfalls must be expected. Requiring health care coverage for all employees and taxing employers to subsidize state risk pools imposes a double whammy on businesses. If employers are the only source of relief for the shortfalls, it will make businesses that provide health care coverage reconsider their position if they have the option.

Conclusion

The National Restaurant Association appreciates the Committee's concern for the over 37 million Americans without health care. However, we cannot support H.R. 4951. We do wholeheartedly support the provision that makes permanent the 100% deductibility for health care for the self-employed. We urge the Committee to further explore this provision and other incentives that will encourage--not bully-- the private sector into providing health insurance for its employees.

Congress can solve the problem of the uninsured worker, but only if it is willing to work with the private sector to develop a fair and flexible solution. Higher benefit costs, lower productivity and widespread unemployment are too high a price to pay when other, more efficient solutions are at hand. In regard to the uninsured unemployed, we feel that this is a national problem--not one to be shouldered by employers alone.

We are willing to help the committee find solutions, provided these solutions take into account the individual circumstances of businesses and their employees and do not result in a counterproductive mandate from Washington.

The 1987 Restaurant Association Industry Operations Report indicates the following net income before tax percentage in 1986 for different categories of foodservice operations.

NET INCOME BEFORE TAXES, 1986

	Percent
Full menu/tableservice	2.4%
Limited menu/tableservice	6.3
Limited menu/no tableservice	8.2
Cafeteria	6.9

STATEMENT

ON BEHALF OF THE

NATIONAL RETAIL MERCHANTS ASSOCIATION

This statement is submitted by the National Retail Merchants Association ("NRMA"), in response to the pending legislation entitled the Employee Health Benefits Improvement Act of 1988 (H.R. 4951). NRMA is the largest national trade association representing the general merchandise retail industry. Our 3,700 members operate more than 40,000 leading chain, department, specialty and independent stores across the country. The bulk of NRMA's membership, however, consists of small, locally-owned retail establishments throughout the nation. Collectively, NRMA members' current annual sales exceed $150 billion and they employ more than three million workers.

While we recognize that this legislation is well-intentioned, it is the view of NRMA's membership that H.R. 4951 would mandate a costly and inflexible employee benefits program which would be unworkable for many of NRMA's members -- particularly its smaller members -- and would impose unnecessary constraints on the proper management of their businesses.

Many NRMA members already provide health insurance coverage for their employees because they recognize such benefits are helpful or necessary to retain and attract talented employees. However, because of the highly competitive nature of the retail industry, and the very narrow profit margins under which our members operate, voluntary programs which allow individual employers to design systems which will work best for their businesses and their employees are far preferable to a mandatory, inflexible program. If enacted, this legislation may well result in reductions of other voluntary employer-paid benefits, such as vacation pay, life insurance and retirement benefits.

Furthermore, this proposed legislation represents only one of a series of pending Congressional proposals which seek to impose government-mandated benefit plans on private employers. NRMA members firmly believe that in a free economy, employers and employees, not Congress, are best able to fashion benefits structures most suited to their needs.

Beyond our opposition to the principle of mandating costly employee benefits, NRMA objects to many of the specific provisions of H.R. 4951. Some of the most troublesome are the following:

1. The legislation would require all employers to provide coverage under a group health plan, and all employees to participate. Such a mandate precludes the crafting of flexible benefit options which may be preferable to a retail worker who may or may not be covered by an existing plan.

2. We understand that the cost of this proposed mandatory insurance program could be in excess of $650 per year for individual employees and $1,600 per year for family coverage. Many small retail establishments simply could not afford such costly employee benefits and would be forced to cut existing staff, reduce the numbers of new hires, and in some exxtreme circumstances, the store may be forced to close. To reduce the risk of these adverse consequences, we urge that employers with fewer than 50 employees be exempted.

3. H.R. 4951 would require that employer-provided health insurance plans cover employees' spouses and their children as well as the individual employees themselves. This is tantamount to mandatory national health insurance coverage funded by employers. If the underlying goal of this proposed legislation is national health insurance coverage, then efforts should be made to provide such insurance through a revision of the tax code, not by placing the financial burden for the program entirely upon employers.

4. H.R. 4951 would permit an employee to opt out of "double coverage" for a spouse or child. However, there is no compelling reason why an employee would ever do so. In fact, employees and their families may be able to obtain 100 percent coverage (in contrast to the Act's 80 percent limitation) when both spouses are covered by their separate employer's plan, or a child who is covered by his employer's plan is also covered by his parent's employer's plan. In addition, H.R. 4951 provides no mechanism to police against double coverage. For the reasons previously discussed, we urge that the family coverage requirement be eliminated or, at the very least, this double coverage problem be dealt with more equitably.

5. H.R. 4951 would limit the premium that can be charged to the employee to 20 percent of the actuarial rate of the plan. Due to the high cost of this coverage and the inherent danger of this program cutting into other employer-provided benefits, we urge that the employee contribution limit for individual employee coverage be raised to at least 50 percent, and if family coverage is mandated, the employee contribution limit for such coverage be raised to at least 70 percent.

6. H.R. 4951 would require employers to provide health insurance to all employees who work over 17-1/2 hours per week. This is not workable in two respects. First, the 17-1/2 hour per week standard is too low. It covers virtually all part-time employees. To require an employer to provide insurance coverage which may cost in the range of $1,600 per year to an employee who may only be earning $3,048.50 per year (e.g., 17-1/2 hours at $3.35 per hour for 52 weeks) is unreasonable. We urge that the minimum hours per week standard be raised to 35 hours per week. Second, the Act does not prescribe any criterion by which to apply the minimum hours per week requirement. We would suggest that an employee be covered only if he/she is regularly scheduled to work the minimum hours per week (i.e., excluding overtime hours).

7. H.R. 4951 does not provide for a minimum period of employment to become eligible for the mandatory insurance coverage. A minimum tenure, such as one year, should be established before an employee is entitled to the mandatory coverage prescribed in H.R. 4951.

8. The proposal calls for first dollar coverage for pre-natal and child care, and contains no exclusion for preexisting conditions. The labor-intensive retail industry with its high employee turnover would be severely burdened by such provisions, particularly in the absence of a minimum tenure requirement.

9. The proposal contains drastic and unworkable non-compliance tax penalties. In addition to the exorbitant $100 per employee per day tax on failure to provide group health coverage, employers may also experience a total loss of group plan tax deductibility for failure to provide existing COBRA-type continuation coverage for terminated employees and their dependents regardless of pre-existing condition.

10. Inclusion of state health care pools contained within the proposal will not assist employers in offering coverage because risk pools have proven to be an ineffective method for addressing problems of the uninsured. The premiums required for coverage are excessive and do not help control health care costs, as only those individuals who anticipate significant health care expense participate in such a pool. This adverse selection leads to risk pool losses, with the funding shortfall made up by participating employees. Of the fifteen states which have established insurance pools, none is self-supporting.

11. By imposing specific employee benefits upon employers with union-represented workforces, H.R. 4951 would infringe upon the collective bargaining process provided for in the National Labor Relations Act.

CONCLUSION

NRMA is sympathetic to the laudable goal of full insurability contained within H.R. 4951. Moreover, we commend the inclusion of provisions which provide 100 percent tax deductibility for the cost of insurance premiums paid by the self-employed businessperson, and federal pre-emption of state mandates as steps in the right direction toward this goal. However, we firmly believe that mandatory health insurance coverage paid for primarily by employers is the wrong way to achieve these goals. We urge the Committee to recognize the fundamental differences which exist from industry to industry and from employer to employer, and to reject any proposed legislation which attempts to mandate a single, inflexible health insurance program to be provided by all employers. We believe that the competitive marketplace should dictate what benefits are provided by which employers to which employees. The system should continue to reflect each company's individual philosophy, operations and needs.

We strongly recommend that the Committee not endorse legislation such as H.R. 4951 which would mandate a specific minimum standard of health insurance coverage, paid by employers, which does not take into consideration the ability of the employer to pay or absorb the cost.

STATEMENT FOR THE RECORD ON BEHALF OF THE NATIONAL SCHOOL BOARDS ASSOCIATION

I. INTRODUCTION

The National School Boards Association (NSBA) appreciates the opportunity to submit this testimony for the record.

NSBA is the only major education organization representing the nation's 95,000 local school board members. Currently marking our 49th year of service, NSBA's purposes include: strengthening the local governance of school districts, promoting access to the highest quality of public education for all Americans, and developing cooperative strategies with other governmental units to finance and serve the public good. Generally, local school board members are elected (96 percent). Accordingly, they have direct political accountability to their constituents for both public policy and fiscal management. As public officials, school board members, like other governing officials, address public policy without consideration to professional vested interests.

II. PUBLIC SCHOOL DISTRICT HEALTH CARE BENEFIT PLANS IN EFFECT

The Employee Health Benefits Improvement Act (H.R. 4951) assumes that there does not currently exist a pattern and practice of employee medical coverage through an employer maintained health care benefit package. Based on this assumption, the Act would compel each employer to provide a federally proscribed "minimum" health benefit package to each employee (and their dependents), and require each employee to accept the health benefit plan (absent a showing by the employee of coverage under a minimum benefit plan from another source). Finally, the Act would cap the total cost of the health benefit plan to the employee, and place financial responsibility for the cost remainder on the employer.

The Act extends to all employers and to all employees who are employed more than 17.5 hours per week without regard to the needs and/or wishes of the employee, the employer's ability to pay, or the financial ability of the employee to pay either the maximum employee cost allowed by the legislation, or more than that amount.

Because the Act assumes the absence of a particular pattern and practice with regard to the availability of cost-effective employer-provided health benefit packages, NSBA believes that it is instructive to begin this Statement with a review of the prevalent pattern and practice among local public school districts.

To that end, NSBA conducted a survey of 415 local public school districts located in 50 States and the U.S. Virgin Islands. Three hundred and eighty-two local public school districts responded to the NSBA survey, the results of which are detailed below (North Dakota, Rhode Island, Vermont, and the District of Columbia did not respond to the survey document).

A. EMPLOYEE PARTICIPATION IN RESPONDENT SCHOOL DISTRICT HEALTH BENEFIT PLANS

All permanent, full-time employees of respondent school districts are provided a health benefit plan either through the local school district or through the state benefit system. Moreover, **28.7 percent** of the respondent school districts **provide a health benefit plan to all school district employees, irregardless of the actual number of hours the individual is employed.**

More than 70 percent of the respondent school districts offer **all part-time employees who are regularly employed more than a minimum number of hours per pay period** a health benefit plan. However, this benefit would be extended to non-contract substitute teachers in only 47.3 percent of the respondent districts.

B. HEALTH PLAN BENEFITS

The health benefit plan of **380 respondent school districts includes in-patient hospital care, out-patient hospital care, and diagnostic testing.** Additionally, 90.6 percent of the health benefit plans provided by respondent districts covered **screening tests. Pre-natal and well-baby care** are covered by the health care plans in **94.8 percent** and **71 percent** of the respondent districts respectively. However, **health care packages**

offered by 15 percent of the respondent districts **offered additional benefits** which include, but are not limited to, dental, vision, prescription drugs, organ transplants, psychiatric care, and skilled nursing facility care.

C. HEALTH PLAN PREMIUM PAYMENT

Twenty-three percent of the repondent school districts paid the **full cost** of the health plan premium for **both employees and their dependents.** Another **24 percent** of all respondent districts paid the **full cost** of the **employees' representative portion of the plan premium.** Over **36 percent** of all respondents contribute a **fixed dollar amount** to the health plan premium. Less than one percent of the respondents required that the employee pay for the entire cost of the health care premium. In the remaining respondent districts, the state was responsible for payment of the health benefit premium.

D. PLAN EFFECTIVE DATE

In **thirty-five percent** of the health benefit plans provided by respondent school districts, **coverage** under the plan **commences the day** the employee **begins employment.** Coverage under the health benefit plan **commences 30 days (or less)** from the date of hire in **36 percent** of the school districts responding to the survey./1 Plan coverage in 14 percent of the respondent school districts commenced more than 30 days following the date of hire.

E. LIMITATION/EXCLUSION BASED ON PRE-EXISTING CONDITIONS

Over 47 percent of the health care plans offered by survey respondents make **no exclusions or limitations** based on pre-exisitng conditions. **A total of 163 respondent school districts** (42.7 percent) **would limit or exclude** health care plan coverage based on the existence of a pre-exisitng condition. Ten percent of the respondents stated that a pre-exisiting condition may limit or exclude coverage under a plan offered by the district, **depending on which plan the employee selected** from among the several offered by the district and chosen by the employee.

F. DEDUCTIBLE PAYMENTS UNDER THE PLAN

Over 25 percent of the health care plans offered by respondents **do not require deductible** payments to be made by beneficiaries. Deductible payments are, however, **required by 63 percent** of survey respondents health benefit plans as follows: An employee with **no dependents** is responsible for a deductible of **less than $250 in 250 school districts; greater than $250 in 28 school districts.** An employee **with dependents** is responsible for a deductible of **less than $500 in 226 school districts; greater than $500 in 44 school districts.**

G. CO-PAYMENT REQUIREMENTS

Over 25 percent of the school district respondents offered their employees health care plans which **do not require** that the beneficiary make **co-payments.** A co-payment **is required by 62 percent** of the health care plans offered by survey respondents. Thirteen respondents did not know if the health care plans offered by their district required co-payments.

Of those health care plans **which required co-payments, 44.7 percent** required a payment of **less than 20 percent** of the cost of the item or service; **52.7 percent** required co-payments of **20 percent or more** of the cost of the item or service.

H. SURVEY SUMMARY

Contrary to the underlying assumptions of H.R. 4951 (that employees do not currently enjoy coverage under employer-provided health benefit plans), **the majority of local public school districts offer health care benefit plans**

/1 Because the state controls the health benefit plan, 16 percent of the respondents did not know plan effective date.

to their employees which are often much broader than the plan required by the Act. Moreover, in many instances, **these plans are both more generous and less costly to the employee than that envisioned by H.R. 4951.**

NSBA believes that it is important to recognize that the health benefit plans offered by local public school districts are the result of the totality of the circumstances in individual school districts. In that regard, NSBA commends to this committee two significant facts.

First, school district health benefit plans are constructed to meet both the needs and wishes of employees and the ability of the school district to pay. Secondly, neither the survey conducted by NSBA nor the Act address the **combination of benefits extended to employees under the benefit package umbrella.** For instance, a school district, at the behest of the employees, may have adopted a "cafeteria plan" which includes a cash option to be used for day care services; educational benefits; or to pay the cost of deductibles, co-payments, pre-existing condition services excluded or limited by the plan; or other treatment not covered by the plan. Alternatively, employees may have requested significant benefits in other areas, including paid sabbatical or extended leave, employer contributions to thrift plans, or creative pension programs.

Therefore, NSBA urges this committee to consider a review of employer-provided health benefit plans **as one benefit among a broad range of benefits** currently provided by local school districts to their employees and at the employees' behest.

Finally, and perhaps more importantly, NSBA urges this committee to recognize the fact that health benefit plans are generally available to all employees of local public school districts. Therefore, **with regard to local public school districts, there has been no showing of a need for federal legislation which establishes a federal right to employees of a proscribed employee health benefit plan.**

III. THE PURPOSE OF THE ACT IS TO SHIFT THE BURDEN OF FINAL PAYMENT FOR HEALTH CARE COSTS FROM THE RECIPIENT OF THE HEALTH CARE SERVICES TO AN EMPLOYER

In recognition of the high cost to individuals of medical treatment in the United States, Congressman Fortney H. Stark (D-CA) introduced the Employee Health Benefits Improvement Act (H.R. 4951). A review of the proposed legislation can only result in the conclusion that enactment would, indeed, **reduce the cost of health care to certain employees and their dependents.**

The Act would effect this result by the creation of both a **federal right** to a minimum health care benefit plan for all individuals (and, in some cases, their dependents) who are employed 17.5 hours per week or more, and a **federal requirement** that the employee exercise the right by participation in the plan. Furthermore, the bill would place a **cap** on that portion of the plan premium to be paid by the employee, and the dollar amount of out-of-pocket deductibles and co-payments that employees could be required to pay under the health benefit plan. The federal right/requirement that all employees who work a minimum number of hours participate in the health benefit plan, coupled with a cap on employee costs, effectively guarantees that participating employees will receive certain health care services for a fixed price, **without regard to the actual cost of the services.**

No person has alleged that H.R. 4951 would either reduce the actual cost of individual health care or stay increases to those actual costs in the future. Rather, the legislation would make minimum medical insurance coverage both a **federal right and a requirement** for those employees who work 17.5 or more hours per week. Thus, it **cannot be said that the purpose of this legislation is to limit the actual cost of health care to the ultimate payor.** Rather, **the purpose of the Act is to shift the burden of final payment for those costs (and all future health care cost increases) from the recipient** of the health care **to an employer** (the health care recipients' employer, the employer of the health care receipient's spouse, or the employer of the health care recipient's parent).

A. THE ACT EXTENDS AN ADDITIONAL RIGHT TO EMPLOYEES WITH NO CORRESPONDING EMPLOYEE OBLIGATION TO UNDERTAKE AN ADDITIONAL ACTION

The **new employee right/requirement** envisioned by the Act **is not coupled with a corresponding employee obligation** to undertake an additional action in return for the new federal right. The proposed legislation would prohibit employees from requesting/receiving, and employers from offering, benefits in lieu of the those enumerated in the Act. Moreover, no provision is contained in the legislation to allow employers to discontinue other discretionary benefits which the employee currently enjoys in order to offset the cost of the new federal right/requirement.

B. THE RIGHT EXTENDED BY THE ACT IS NOT CAPABLE OF EQUAL ENJOYMENT BY ALL PERSONS TO WHICH THE RIGHT EXTENDS

The dual nature of the legislation (simultaneous imposition of both a right and a requirement) results in a disparity of enjoyment among employees. To wit: Although the legislation extends a right which results in a desirable benefit to some employees, it mandates a requirement that results in a burden to other employees. For instance, the legislation mandates that the **employer shall provide and the employee accept** a benefit package which, for many, contains benefits which are **incapable** of being enjoyed by the employee (e.g., pre-natal and well-baby care). Nevertheless, neither the employee nor the employer can control the content of the minimum benefit package based on the actual needs or wishes of the employee and the ability of the employer to pay.

C. STATUTES GOVERNING MINIMUM EMPLOYMENT STANDARDS ARE LIMITED TO ACTUAL EMPLOYEE SERVICES RENDERED AND BASED ON ACTUAL COMPENSATION PAID. MINIMUM EMPLOYMENT STANDARDS DO NOT EXTEND BEYOND THE RELATIONSHIP BETWEEN AN INDIVIDUAL EMPLOYEE AND HIS EMPLOYER.

Proponents of H.R. 4951 characterize it as a minimum employment standard not unlike minimum wage/maximum hour provisions or the requirement that employees and employers pay social security/medicare taxes. However, an examination of both minimum wage/maximum hour provisions and the social security system reveals that the **requirements of H.R. 4951 are, in fact, significantly different from those which establish minimum employment standards.** This is so for five reasons.

First, **from an employee's perspective**, minimum wage/maximum hour standards are **uniformly capable of enjoyment** by all employees on an equal basis. As discussed earlier, herein, **all employees are not capable of uniform enjoyment of the fruits of H.R. 4951 on an equal basis.**

Secondly, **for employers, cost of compliance** with minimum wage/maximum hour standards and social security/medicare taxes is **fixed by statute.** Changes to either employment standards or employment tax rates can be made only by Congressional amendment, following a full opportunity for public participation in the political process. **Conversely, H.R. 4951 establishes fixed employee costs only. Employer costs are at all times subject to rate-setters of privately owned insurance companies.**

Third, the minimum wage/maximum hour provisions are directed at **compensation rates for actual employee services rendered.** Minimum wage provisions establish the minimum hourly rate at which an employee must be **compensated for actual services rendered.** Maximum hour provisions establish an hourly cap beyond which an employee must **receive additional monetary compensation** (or in some instances, compensatory time in lieu of cash) **for actual services rendered.** In either case, a condition is placed on both employee and employer for which each receives a corresponding benefit.

Contrary to the corresponding benefit and burden flowing from the minimum employment standard provisions, the Act extends a benefit to certain employees (and their dependents) and imposes a condition on the employer with neither a benefit to the employer nor a condition to the employee (or his dependents).

Fourth, the **minimum wage/maximum hour provisions do not extend to all employees.** Rather, those provisions apply only to those employees who, based on their salary and job responsibilities, perform the most minimum of tasks. Thus, a professional might at once provide an employer with actual services far exceeding forty hours per week and receive monetary compensation below the minimum wage for their time by virtue of the fact that their job responsibilities and annual salary exclude them from the minimum wage/maximum hour provisions.

Under the Act, **consideration of the financial ability of the employee to pay is neither proposed nor allowed.**

Fifth, **minimum employment standard statutes extend only to actual hours worked** by an individual employee. Social security/ medicare taxes are **imposed on actual wages paid** to an individual employee. In that regard, the employer may both predict and control his current and future, aggregate and indivdual employee costs.

Under the Act, the employer is **incapable of either controlling or predicting current and future, aggregate and individual employee cost** of the health benefit plan. **This is so because the right to the benefits enumerated by the Act reach beyond the individual employee to include his dependents.**

IV. CONCLUSION

The Act extends to certain employees (and their dependents) a right to an employer-provided health care benefit plan. Proponents of the Act have characterized this federal right as a "minimum employment standard." However, as discussed previously, this characterization is inaccurate. In large measure, this is so because the Act at once creates a fiscally consistent right in the employee and an unknown fiscal responsibility in the employer. Moreover, the Act reaches beyond the individual employee to capture the employee's dependents. Finally, the Act would bestow a new federal right on the employee (and his dependents)/burden to the employer with no corresponding condition to the employee/benefit to the employer. Therefore, NSBA believes that the Act does not establish minimum employment standards. Rather, the intent and effect of the Act is the creation of a new federal right — a right to certain employees of a benefit in the form of a federally proscribed health benefit plan.

NSBA supports the concept of employer-provided health benefit plans. As discussed previously, local public school districts generally offer employer-provided health benefit plans to their employees. However, NSBA believes that the content of these plans should not be the subject of federal legislation, but rather the subject of negotiation between the employer and the employee.

PERSONALIZED BUSINESS CONSULTANTS, Inc.
AN INDEPENDENT SERVICE ORGANIZATION

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September 29, 1988

Mr. Robert J. Leonard
Chief Counsel
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth
House Office Building
Washington, D.C. 20515

Re: Hearings of HR4951-Employee Health Benefits Improvement Bill of 1988

Dear Mr. Leonard:

While I applaud efforts to secure health care coverage for all Americans, as usual you have gone too far. Small businesses cannot afford to guarantee coverage for any employees who work 17 1/2 hours a week. Small business women and men don't have your millions to work with. We struggle to survive. As it is, we spend over 1/3 of our time and money complying with various government requirements and taxes.

A more reasonable approach is to require health coverage to be offered all non-seasonal employees working 17 1/2 or more hours a week with the employee paying 50% of the cost and employees who work 17 1/2 - 30 hours a week must pay 25% of the cost, with the cost of employees working more than 30 hours a week being paid by the employer for the employee coverage only. Actually, the addition of IRC Section 89 virtually requires this with one exception, health care coverage is not mandated.

Small businesses will be forced out of business and there will be fewer jobs for minorities, the unskilled, and students, with this type of legislation.

Congress, with its various laws in the area of Defined Benefit Plans, has already destroyed those plans for most small employers. And worse yet, small businesses are discouraged about any qualified Plan due to excessive complexity and constant changes, which drives up the cost of administration and compliance to unreasonable levels.

The Section 89 laws, especially those dealing with Cafeteria Plans, unfairly discriminate against small business. Many businesses who do not discriminate as to benefits or eligibility still cannot set up a Cafeteria Plan because there is no safe harbor rule when benefits and eligibility are the same for non-key and key employees. Those Plans must still comply with the 25% rule and unreasonable average benefit rules. This is not only unfair but stupid on Congress's part since it merely causes small business employers not to provide any employee benefits.

The "little" taxpayer, along with self-employeds - the ones not covered by a big employer's generous health plan - were discriminated against yet again when Congress eliminated medical deductions up to 7.5% of Adjusted Gross Income. If health care is such a priority - and it is - pass some reasonable legislation like allowing a full deduction for all unreimbursed medical expenses, including the cost of insurance premiums, where employees are not covered by any employer paid health plan. Allow a deduction of 75% of the first $2,000 and 100% thereafter for out of pocket health care where an employee is covered by an employer paid health care plan. Extend the catastrophic health care coverage to all Americans, regardless of age.

If Congress continues to discriminate against, and make Small Business it whipping boy - it will destroy many Small Businesses and directly cause even more to avoid providing any benefits for employees. Too bad some of the technocrats don't have to "intern" in the real business world rather than hide behind the cloak of security given government employees and the professional politician.

Sincerely,

Gloria L. Aaberg-Sneath

Gloria L. Aaberg-Sneath, CPC, CEBS, APA, FLMI
President

cc: Vice President Bush

STATEMENT
OF THE SELF-INSURANCE INSTITUTE OF AMERICA, INC.
ON
EMPLOYEE HEALTH BENEFIT
IMPROVEMENT ACT OF 1988 (H.R. 4951)
TO THE
SUBCOMMITTEE ON HEALTH
WAYS AND MEANS COMMITTEE

SIIA appreciates the opportunity to express its views in connection with the Subcommittee's consideration of "The Employee Health Benefit Improvement Act of 1988" (H.R. 4951).

SIIA is a national association of over 600 members including employers, third-party administrators, insurance companies, reinsurance companies and other interested parties representing over 30 million participants. Dedicated to the advancement of self-insurance, SIIA is the only association in the U.S. which represents firms, professionals and organizations which participate in the broad spectrum of self-insurance.

Under H.R. 4951, all employers would be required to provide a minimum health benefits package to employees (working more than 17.5 hours per week) and their dependents. Employers would be required to pay at least 80% of the cost of the plan. A mandatory health plan would need to provide benefits similar in amount, duration, and scope to Medicare, except that a deductible payment of up to $1,000 per individual or $1,500 per family may be imposed by the plan, plus maternity and child care benefits. Employers who fail to provide benefits would face a penalty of $100 per employee per day.

SIIA opposes H.R. 4951 because it would: (1) result in less rather than more access to health coverage; (2) raise costs and hurt the flexibility of large and small employers from designating benefits packages that meet employee needs; and (3) result in reduced employment and diminished competitive strength for U.S. business.

Historically, Congress has not enacted legislation mandating specific benefits in private group health plans. Instead, Congress has favored policies which have promoted the growth and success of a private, voluntary approach to health care benefits for workers. SIIA believes that these policies have served the needs of American workers and their families well and should not be modified at this time.

The current federal legal framework has been vital to the success of the present private-sector approach in meeting consumer health needs. This has been accomplished through broad tax incentives for employers to provide group health care benefit plans for their employees -- without federal "strings" dictating the terms of their plans. Employers spent more than $150 billion in 1987 on health care for employees and their families and provide about 85 percent of total private health care coverage to 135 million people under age 65 through voluntary employer-sponsored plans. Employers also pay a large share of the cost of public health programs through taxes and contributions. This private sector system has effectively funded the most advanced health care system in the world.

Increasingly, there has been a tendency to look to the voluntary private health care system as the vehicle to provide solutions to certain health care problems -- such as the problem of the uninsured. During a period of federal budget deficits and spending reductions, it has been good "politics" to seek solutions to social problems through the private sector instead of through new federal spending programs.

No one would disagree that adequate health care coverage for all who need it is an important societal goal. Indeed, we agree that it is unacceptable that some Americans are denied access to health care because they are unable to pay for it or because they are not covered by health insurance. However, it is important for all elements of society -- not just the employer community -- to commit the resources needed to achieve that goal. H.R. 4951 places the total burden for this societal problem on the employer community -- an approach which surely will weaken this proven successful system. At a time when a consensus for national health insurance has not developed, the mandatory approach appears to be a "back door" attempt to create a legal framework leading to a broader national health program. Moreover, some observers have already noted that a minimum health package such as that proposed would be a focal point down the road for myriad federally mandated benefit "add-ons".

Our economy has created 12.4 million jobs in the last 4 years -- most of them small businesses, which are particularly at risk from increased labor costs. For small employers operating at a low profit, or start-up firms with no profit margin, the new federal program would be particularly burdensome. National surveys indicate that concern over government mandated health benefits has replaced concerns about liability insurance as the number one worry for small business. Many small firms faced with the federal mandate would be forced either to lower wages, reduce their workforce, or discontinue operations. These actions would result in less rather than more access to health care coverage and would result in reduced employment. Additionally, the higher health care costs would not be limited to small business but would impact on medium-size and larger businesses who purchase services from smaller firms. Thus, the proposed mandatory approach will create not only a small business problem, but a problem which impacts on all business. More specifically, the mandatory approach will contribute to higher inflation and will tend to make U.S. firms less competitive with foreign firms.

No single solution is likely to solve the problem of the uninsured in the United States. In the search for solutions to the problem of expanded health care coverage, rather than target business -- and especially small business -- it may be useful to recognize certain realities:

(a) additional financial resources, in the form of direct government funding, tax expenditures, and private sector funding will be necessary.

(b) to help assure access to adequate health care for those in the labor force, existing employer incentives to provide health insurance to employees and their dependents should not be jeopardized; there must be additional incentives for individuals and small employers to provide benefits. In this connection, the provision which would extend the 100 percent health benefits tax deduction to self-employed workers deserves support.

(c) mandating that businesses offer and/or pay for expanded coverage undermines the voluntary, flexible, private-sector employee benefits system. Shifting the burden for expanded health coverage to employers is not a cost-free way of dealing with expanded coverage. Such a mandate leads employers to reduce overall health care coverage, abandon their health plans or decide against starting health plans.

(d) the additional cost and burden of mandates diminishes our nation's competitiveness in a global economy by increasing employer labor costs.

Moreover, recognizing the need to address the coverage problem, it is critical that any programs considered for this purpose should not interfere with the current ERISA federal preemption of state regulation of self-insured welfare benefit plans, which has demonstrated such positive results in meeting the health needs of employees and their families.

All of this underscores the need to reexamine closely all the potential effects of an attempt to reverse the traditional role played by the voluntary health care system under which employer sponsored group health plans deliver benefits. In this regard, we support proposals which would require the potential employment impact of increases in labor costs to be examined in their totality before it is decided whether the social benefits to be achieved by mandated benefits legislation should be considered.

SIIA appreciates the opportunity to submit its views in connection with the Subcommittee's consideration of H.R. 4951.

Webb Clinic of Chiropractic

[illegible] S. WESTMONTE DR. SUITES H I J.
ALTAMONTE SPS. FL. 32714 (305) [illegible]

WM. P. WEBB II, B.S. D.C., Director

H.R. 4951

Suggested addtions-changes to the bill:

That an employee must be employed for a minimum of 6 weeks before any insurance becomes effective.

That Chiropracitic care be included in the bill as equal as any other healing arts professional: that he/she be paid the usual and customery for his/her services and the services that are paid for be covered by the state rules and regulations allowing him/her to pracitce.

Respectfully Submitted by:

Wm. P. Webb II, B.Sc.D.C.